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13 September 2008

Health tsar: Your time has come

The best of BPC 2008

See page 6

- **PSNC reveals funding rescue package** See page 4
- **Hit by prescription switching? Complete our survey** See page 10
- **Deal or no deal? The DH's stoma care saga** See page 29

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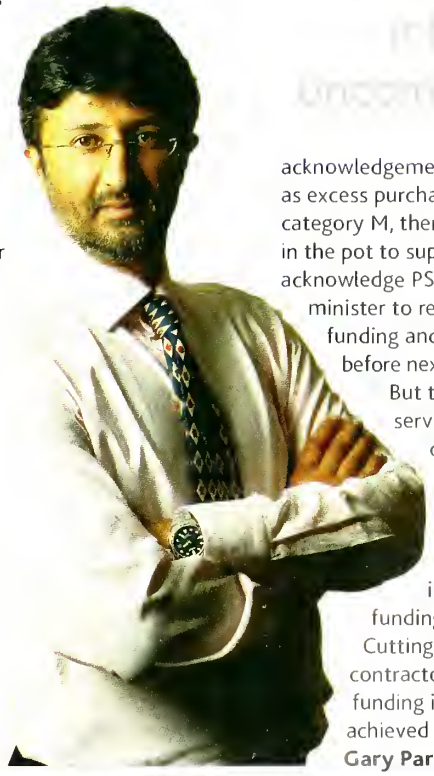
Comment from the Editor

Whichever way you look at it, the latest contract funding announcement for England will provide welcome relief for community pharmacy contractors.

An uplift in total funding of £280 million, which includes recognition of the significant regulatory burden faced by community pharmacy, goes some way to addressing the devastation caused by last October's £400m category M clawback.

In recent months, C+D has highlighted the stark news that some companies have had to lay off staff and cut investment as cash flow dried up. Everyone from the smallest independent to the largest multiple has felt the pinch – it has been without doubt an uncomfortable year for employers and employees as companies have cut costs and trimmed what little fat they had.



So the news from PSNC that practice payments will treble, giving the average pharmacy dispensing 6,000 items per month a £3,000 increase in monthly income, will be gratefully received by those that qualify for the payments.

More importantly perhaps is the acknowledgement by the Department of Health that, as excess purchase profits have been reclaimed through category M, there just hasn't been enough money left in the pot to support community pharmacy. We should acknowledge PSNC's achievement in persuading the minister to recognise this by agreeing to the extra funding and to undertake a cost of service inquiry before next year's funding is agreed.

But time remains a key issue here. A cost of service inquiry can take months and of course there is no guarantee that the ensuing negotiations between PSNC and the Department will deliver the fair funding we seek. The past year has demonstrated all too clearly the harsh impact of a mismatch between agreed funding levels and actual costs incurred.

Cutting the time lag between identifying contractors' costs and agreeing a level of fair funding is essential, but quite how it will be achieved is another matter.

Gary Paragpuri, Editor

Contents

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Contract rescue package bids to bring contractors back from brink

PSNC delivers 14 per cent boost in 2008-09 funding, including £150 million transitional payment

Jennifer Richardson

Practice payments in England are set to treble under this financial year's NHS funding arrangements, PSNC has announced.

Total contractor funding for 2008-09 has been boosted by £280 million to £2.23bn, an increase of 14 per cent, following what the contract negotiator called "lengthy negotiations" with the Department of Health.

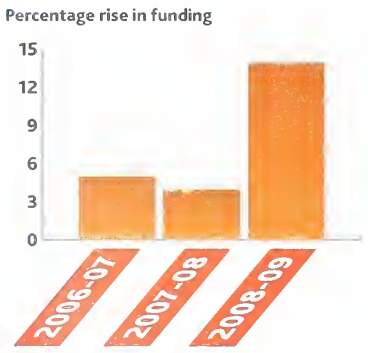
From October until March, 2009 practice payments will increase from 34.5p to 101.1p per item, an increase of 193 per cent. A contractor dispensing 6,000 items a month will therefore see a £3,000 increase in his or her monthly income for the rest of the financial year. However, this will not be reflected in NHS payments until January.

The £280m uplift includes a "transitional payment" of £150m, pending a full cost of service inquiry to be carried out "as soon as possible". This was required because contractors were suffering an "unsustainable shortfall in funding", PSNC said.

In a letter to contractors, PSNC chief executive Sue Sharpe admitted: "It has become apparent that the contract funding is inadequate to support pharmacy contractors, and makes investment to deliver new clinically-based services impossible."

The shortfall arose after the implementation of the 2005 contract because the cost basis contained under-estimations, PSNC head of NHS services Alastair Buxton told C+D. "It would appear that some of the costs were understated," he said. PSNC hoped a cost of service survey would be in time to inform 2009-10 negotiations.

The recent "information vacuum" surrounding the funding negotiations was due to the necessity for them to be conducted "patiently, behind closed doors", Mrs Sharpe added in her letter.



£25.5m sweetener for rise in red tape

A 14 per cent boost in NHS contractor funding for 2008-09 includes a cash injection of £25.5 million to cover increased regulatory burden.

This is a 50 per cent bigger uplift associated with administrative costs than in the previous financial year. It accounts for – among other elements – the costs to contractors associated with the Prescription Pricing Division's (PPD) automated scanning system. This includes extra time required to sort prescriptions and declare out-of-pocket expenses, and the secure transportation of scripts, but is distinct from switching compensation.

The £25.5m also includes funding for changes to CD regulations, obtaining and renewing EPS smartcards, and complying with NPSA alerts.

101.1p Practice payments Oct-Mar 09

£150m To plug "unsustainable shortfall in funding"

£25.5m For increased regulatory burden

14% Rise in overall funding

£2,000 Increase in pre-reg training grant

£1 Extra per MUR

Deal brings relief, but may not be enough

Contractors have welcomed the increase in practice payments, but some say the rise does not go far enough and have called upon PSNC to take further action. Others warned that more work was needed to ensure the situation remained stable.

Fin McCaul, chair of the Independent Pharmacy Federation, said he thought PSNC had done a good job, but that the increases were "nowhere near enough".

Mr McCaul explained: "The money is going to come too late – I need an emergency payment now. Cash flow is a real problem... the cost inquiry could take 18 months."

He called on PSNC to think outside the box, and said: "Instead of tinkering with a contract that's not working, we should be putting it in the bin and starting again."

Other independent contractors also expressed concerns about the agreement. And John D'Arcy, interim managing director of Numark, warned that although the average pharmacy might benefit, there would always be some falling below that average who could even end up worse off. He added that it was still difficult to make business plans as "we seem to have money taken away one minute, but given to us the next".

But some larger companies were more positive about the deal. Kirit Patel, chief executive of Day Lewis, said the increase in practice payments put "more money back in the right place, ring-fenced", meaning more investments could be made.

John Evans, superintendent pharmacist at Asda, said PSNC had done a good job, but warned they needed to "keep on top of this" and maintain control of funding. He said: "We don't want to go back to the yo yo funding that we have had over the past few years." **ZS**

Contractor views

"Category M has been disastrous so this will help alleviate our financial worries. But I'm not confident about PSNC. It looks like a nice improvement, but what's the small print? I'm suspicious about the small print. I'm waiting to see the full extent of the measures at the end of the financial year."
Paul Knight, Murrays Pharmacy, Shropshire, dispenses around 12,000 scripts per month

"They have increased practice allowances on the one side, but on the other there's going to be a category M clawback. I don't know how they did their calculations but I can't get that £3,000 figure doing the sums for my business. In fact it looks like I will be worse off. It doesn't fill me with confidence; I hope I'm wrong."
Prakash Mahtani, Warwick Pharmacy, Pimlico, dispenses 5,000-6,000 scripts per month

Cat M clawbacks revealed

Improvements in pricing structure but still inconsistencies, says Sigma MD

Jennifer Richardson

A further £65 million is set to be taken out of contractors' generic purchase profits over the second half of this financial year.

But alterations to this October's category M tariff nonetheless indicate that the Department of Health had listened to some concerns about the pricing structure, said generics expert Bharat Shah.

Category M reimbursement prices will be reduced by an average of 16 pence per item, equating to £32.5m in each of the remaining quarters of 2008-09, PSNC announced as part of this year's contract funding arrangements, published this week.

This was based on the 2007-08 margins inquiry, it said, which indicated that pharmacists would have earned an estimated £65m excess purchase profits, above the agreed £500m, in the first half of this financial year. This estimate was provisional pending the results of the 2008-09 margins inquiry.

But despite the cuts, the October category M tariff showed some "sympathy" to contractors, said Sigma managing director Mr Shah.

The Department of Health had removed the "stupidity" of having generics reimbursement prices as low as 28p, Mr Shah said, with the lowest now 81p.

But the DH still hadn't addressed the problems of different reimbursement levels for the same molecule in different pack sizes, he said, which "made a mockery of the Drug Tariff".

For example, the best pack size for reimbursement for metformin had switched from 84s to 28s, Mr Shah said. He urged all contractors to lobby the DH for pack size harmonisation.

In addition, there were still more than 100 products priced above the brand equivalents, Mr Shah added.

Bharat Shah: DH seems to be listening

Demands for compensation as another fuel levy hits pockets

The cost of service review promised by the DH must take into account fuel surcharges being imposed by wholesalers, industry chiefs have said, as a third wholesaler announced a levy.

AAH will charge £14 + VAT per month from October as a result of "record high fuel prices", which hit £1.33 per litre this summer. Wholesalers UniChem and Phoenix have already introduced fuel levies.

AAH said it had been forced to introduce the charge after making "every effort to absorb the increased cost" but that the charge would be kept under review and could rise or fall in future.

The fee will not apply to medicines supplied under direct to pharmacy or agency deals, AAH confirmed.

Mark Griffiths, chairman of pharmacy support group Cambrian Alliance, said although he would "like to not pay it" he understood the need for the charge.

John D'Arcy, interim managing director at Numark, said the surcharges were "hardly surprising", but that they should be factored into the cost of service review promised by the DH.

AAH said it too believed there was a "strong case" for the surcharge to form part of funding agreements, and that it would work with pharmacy bodies to help put this case to the DH.

PSNC said it had already begun discussions with the DH on the costs of fuel surcharges.

Both AAH and UniChem now apply a £14 monthly fuel surcharge. Phoenix bills £9.75 a month. **ZS**

Pump up: "fuel levies should be factored into cost of service review"

News in brief

Join the C+D team

C+D is looking for a pharmacist to join its editorial team as a full-time reporter based at its office in Tonbridge, Kent. If you're eager to learn and have a keen interest in pharmacy news and politics, email your CV and covering letter to C+D editor Gary Paragpuri at gparagpuri@cmpmedica.com

Support staff training

Free with OTC next week is the latest training module sponsored by McNeil. Updated with the latest changes to cough medicines for the under-twos, the module allows staff to test their understanding and receive a certificate. The module can also be downloaded from www.chemistanddruggist.co.uk/stafftraining

Skills for Public Health

Watch out for the first module of the new Skills for Public Health distance-learning course, free in this week's C+D. Written by public health experts and practising pharmacists, topics covered in the 10 modules include advice on running pharmacy services and the evidence base for interventions such as diet, smoking cessation, alcohol and drug misuse programmes.
For more information go to: www.chemistanddruggist.co.uk/skillsforpublichealth or call 01732 377269.

Rx factor winners

The RPSGB has announced the four winners of its Rx factor competition to find media spokespeople for pharmacy. Find out who the quartet are at www.chemistanddruggist.co.uk

NCSO update

The DH and the National Assembly for Wales have agreed to allow NCSO endorsements for the following item for September 2008 prescriptions: pseudoephedrine 60mg tablets.

Boots advice live online

Boots is offering out-of-hours minor ailments consultations over the internet following a revamp of its website. The Boots Live Pharmacist Service enables customers to email questions between 6pm and 11.30pm, Monday to Saturday.
www.chemistanddruggist.co.uk

BPC briefs

Responsible pharmacists

Pharmacists have just one year to fully prepare themselves for the changes which will be brought in by responsible pharmacist regulations. The regulations are due to be laid this month, and will come into force by October next year, Jeannette Howe, head of pharmacy at the DH, reported.

Tackle obesity

Community pharmacy-based weight management services should play a key role in the battle against obesity, according to Dr Colin Waine, chair of the National Obesity Forum. Dr Waine said the profession's help was "urgently" needed.

Join professional body

Pharmacists were once again urged to join the new professional leadership body, by Nigel Clarke, chair of the transitional committee overseeing its formation. Mr Clarke said patients would expect pharmacists to be members. To those asking why they should join, he said: "Why should you not join?"

Team pharmacy praised

England's chief pharmacist has praised pharmacy representatives for pledging to work as a team on white paper proposals. Keith Ridge backed a statement of co-operation released by PSNC, RPSGB, CCA, AIMp and NPA last week.

Been seen to be green

C+D has been lauded by Department of Health chiefs for raising awareness of environmental issues in the profession. Gul Root, principal pharmaceutical officer at the DH, said articles from C+D's Green Month series demonstrated the key role the profession could play in championing green practice.

Call for expert voice

The profession is missing an expert voice in the commissioning of pharmacy services, the DH has said. England's chief pharmacist Dr Keith Ridge asked BPC delegates: "In reality, who in pharmacy are the experts in commissioning? I throw down the challenge – let's have some."

Forgive and forget, asks Society president

"Tragedy" if RPSGB fails to form successful professional body, BPC told

Jennifer Richardson

The RPSGB president has asked members to forgive and forget the Society's past shortcomings and contribute to its transition to a new professional body.

Steve Churton said he was aware the Society had sometimes failed to meet members' needs, and had not always listened "as much as it should have done", in his inaugural speech to the British Pharmaceutical Conference (BPC), in Manchester this week. He called on members to "draw a line across the page" and focus on the future.

Mr Churton admitted: "The interests of you, the hard-working members of our profession, have often been overlooked... we have fallen short of your expectations, and I am sorry that that is the case. Having said that, I want us to put those shortcomings behind us."

Mr Churton highlighted the Society's input into Lord Darzi's NHS review and the Health Select Committee's inquiry into the recommendations as evidence that the new body would "continue to ensure that the voice of the profession is heard at the highest levels of government".

Failure to form a successful professional body would be a "tragedy", Mr Churton said. "If we fail, we will have thrown away the opportunity to have a strong and united voice for our profession."

A prospectus for the new professional body would reach members around new year and would be followed by a consultation and vote, Mr Churton added. "We will act on what you tell us you want from a new professional body."

Photo Joe Miles

Steve Churton: need to put the past behind us and move on

Can you forgive and forget?
jrichardson@cmpmedica.com

Primary care needs you, says tsar

Pharmacy's potential contribution to primary care has been overlooked in the past, but the drive to change that must come from within the profession itself.

That is the view of the government's primary care tsar, who delivered the Department of Health's keynote speech at this week's British Pharmaceutical Conference in the absence of pharmacy minister Dawn Primarolo.

David Colin-Thomé said: "Community pharmacy has not been given its rightful place in the sun, and, given the huge amount of people who visit them and that potential, we haven't tapped into that resource."

He added: "How do we, through the work of the pharmacy world itself, raise your profile? A lot of the energy has to come from yourselves."

Dr Colin-Thomé encouraged pharmacists to get involved in proposals for integrated care pilots, an initiative to encourage inter-professional collaboration as part of the DH's primary and community care strategy. Interest had been so high the DH had decided to remove the original 10 to 15-pilot limit, he said. "You need to make sure that as bids go in you are part of these."

He concluded: "I'm sure your profession's up to it but, at the very least, you need to break a few windows to get there." **JR**

No break for six in 10

Six in 10 pharmacists never take a break at work, their trade union has revealed.

The majority of those who did not take time out felt they had put patients at risk by doing so, the Pharmacists Defence Association (PDA) told delegates at the BPC.

The findings form part of a study by the union into the stress levels of employee and locum pharmacists. Over 1,500 workers had completed the study so far, the PDA said.

According to the PDA, respondents said they did not take breaks because they were too busy or were expected not to by employers. **MG**

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Dispensary
TALK

How many times have you been to the British Pharmaceutical Conference?

"Never. I suppose location is the main reason why. Being based in Norfolk it is a bit of a trek."
Geoff Ray, Total Health Pharmacy, Norfolk

"Once. I was thinking about going this year, however the timings of the sessions that interested me clashed with a prior commitment."
David Evans, Manor Pharmacy, Derbyshire

Next week's question: Is the 2008-09 funding package the best contract deal yet? Vote at www.chemistanddruggist.co.uk

Did you hear the one about the tsar, the president and the page 3 model?

Read Max Gosney's EPC blog on page 38

Drug disposal discs put staff at risk of attack

Industry uproar over plans to make vans carrying drug waste display ID

Ann Shuttleworth

Pharmacists could be targeted by criminal gangs if they are forced to display discs on vehicles that provide drug disposal services, pharmacy bodies have said.

A Defra consultation recommended small businesses be required to take part in a registration disc scheme to identify vehicles used to carry waste.

However, the move would put the profession at risk, industry bodies including the NPA and PSNC said.

"Any external identification could increase the risks of the driver being targeted... the criminal fraternity may target the vehicle for drugs," the groups said.

The warning came as stakeholders roundly rejected government plans to increase red tape around the disposal of medicines.

The consultation recommended that small businesses be required to register to carry their own waste to a central point for disposal. This would place an "administrative and financial burden" on pharmacies, stakeholders warned.

The move could lead to pharmacies withdrawing from the service and an increase in fly-tipping and disposal of drugs in domestic waste or foul sewers, the groups added.

Many pharmacies remove unwanted medicines from the homes of patients to whom they deliver prescriptions for safe disposal, the bodies said. However, the response claimed a disc scheme would make it difficult for pharmacies to offer this free service.

Pharmacies often use several vehicles to visit patients, and each would require a registration disc, creating an incentive for them to withdraw the service, the groups added.

The consultation response was issued by AIMp, Community Pharmacy Wales, the CCA, NPA and PSNC. The Defra consultation is due to close this week.

Will displaying a disc put you in danger?
haveyoursay@cmpmedica.com

Contractor Rajesh Vaitha (right) greets Leicester East MP Keith Vaz outside his Medicine Chest Pharmacy. Mr Vaitha introduced Mr Vaz to a Leicester City PCT pilot of cardiovascular screening in community pharmacies during the visit, part of C+D's Building Bridges campaign to get MPs to visit their local pharmacies and build the profession's political profile. Duty pharmacist Shezad ali Mohamed carried out the screening service on Mr Vaz

Dispensing GPs dispute predicted white paper savings

The Dispensing Doctors' Association (DDA) has questioned Department of Health estimates of the savings to be made by changing the distance criteria between pharmacies and dispensing doctors.

The DH claims stopping GPs dispensing within a certain distance of pharmacies will save £23 million, but the DDA says Prescription Pricing Authority and population figures do not support the estimate.

David Baker, chief executive of the DDA, said: "While the DH figures are not demonstrably false, they are questionable to say the least."

The figures were published as part of impact assessments into DH plans to implement proposals in the pharmacy white paper.

Mr Baker also said a change in the distance criteria would encourage pharmacies to move closer to dispensing practices, threatening to put them out of business.

"It makes good business sense for a pharmacist to move into one of these areas," he said. "At the moment the reserved location offers protection. You don't get unviable pharmacies and it protects the other services of rural GPs." **AS**

GPs in row over flu vaccination

Pharmacy leaders have hit back after GPs criticised an increase in pharmacy-led flu vaccination services this winter.

GP representatives claimed practices may be left with unused stock after Sainsbury's and Boots revealed plans to extend vaccination schemes.

However, Alastair Buxton, head of NHS services at PSNC, said the professions could work in unison. He said: 'We should be working together to improve overall coverage."

Community pharmacies can target priority groups that are hard to reach, such as younger people with asthma, COPD and diabetes, he added. Pharmacies were also open Saturdays and later in the evenings than many GP surgeries, Mr Buxton stressed.

Boots plans to offer vaccinations in 219 stores from October, while Sainsbury's is increasing from around 60 stores last year to 130 this year. **AS**

Have you been hit by prescription switching?
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[1,2] Data on file

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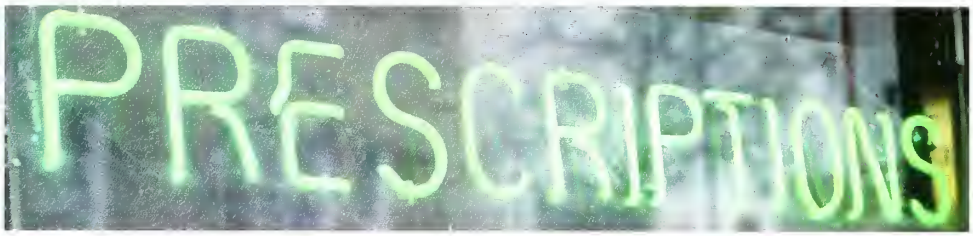
Product Information: Hedrin 4% Lotion Spray. **Presentation:** cutaneous solution containing 4% dimeticone w/w. **Indications:** for the eradication of head lice infestations. **Dosage and administration:** Adults and children over 6 months: Apply sufficient lotion to cover dry hair from the base to the tip to ensure that no part of the scalp is left uncovered. Work into the hair spreading the liquid evenly from roots to tips. Allow hair to dry naturally. Hedrin should be left on hair for a minimum of 8 hours or overnight. Wash out with normal shampoo, rinsing thoroughly with water. Repeat the treatment after seven days. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions and Warnings:** Discontinue at the first appearance of a skin rash or any other signs of local or general hypersensitivity. For external use only. If accidentally introduced into the eyes, flush with water. **Side Effects:** Minor adverse events include an itchy or flaky scalp and dripping/irritation around the eyes. **Product Licence Holder:** Thornton & Ross Ltd, HD7 5QH **Legal Category:** P **Price (MRRP ex VAT):** 120ml £10.20 Trade £7.14 **Product Licence No.** PL00240/0137 **Date of preparation:** June 2008

Available on FP10

C+D's prescription switching survey: have you been affected?



Completed forms go into a draw to win £50

The launch of automated prescription processing has been plagued by controversy. C+D has reported on numerous contractors who claim to have lost thousands of pounds after having prescriptions switched from exempt to paid. A £7 million compensation deal has been brokered between PSNC and the Prescription Pricing Division (PPD). Yet, the extent of the problem remains unclear. With the compensation package only covering switches up until this June, C+D wants your help in establishing the scale of the problem. Simply fill in the survey and send it back to us by Saturday September 20. All entrants will be entered into a prize draw to win £50

1. In the past year, has the number of prescriptions switched by the PPD:
a) Increased ❒
b) Decreased ❒
c) Stayed the same ❒

2.On average, how long per month do you spend sorting prescriptions for submission to the PPD?
a) 0-1 hour ❒
b) 1-3 hours ❒
c) 3-5 hours ❒
d) 5-10 hours ❒
e) 10 hours or more ❒

3. Over the past five years has the amount of time you spend sorting scripts for submission to the PPD:
a) Increased ❒
b) Decreased ❒
c) Stayed the same ❒

4. How confident are you that the PPD processes your payments to a high degree of accuracy?
a) Completely confident ❒
b) Fairly sure ❒
c) Quite sure ❒
d) Doubtful ❒
e) Definitely not ❒

5. How has your confidence in the accuracy of pricing changed since the launch of automated processing?
a) No change ❒
b) More confident ❒
c) Less confident ❒

6. Were you told you needed to change your prescription submission process before the PPD launched its new automated system?
a) Yes ❒
b) No ❒

7. How effective have you found the PPD at dealing with your queries over prescription payments?
a) Highly efficient ❒
b) Efficient ❒
c) Satisfactory ❒
d) Poor ❒
e) I've never had to contact the PPD ❒

8. How would you rate the £7m compensation deal agreed between PSNC and the PPD for prescription switching?
a) Delighted with the deal ❒
b) Satisfied that it goes a long way towards compensating pharmacists ❒
c) Not convinced it goes far enough ❒
d) Very disappointed by the package ❒

Your name: _____

Pharmacy name and address: _____

Postcode: _____

Email address: _____

Daytime phone number: _____

Post the completed survey to: Prescription Switching Survey, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE or fax to 01732 367065

All completed entries will be put into a draw for the £50 prize

NEW

Pharmacy-Only Dispensing Range*

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FOR ALL YOUR OPEN DOCTORS' PRESCRIPTIONS FOR GLUCOSAMINE SULPHATE 2KCL

PROFESSIONAL DISPENSING PACK

With Margin!

GluCosamine Sulphate 2KCL PDP®	PACK SIZE	MOQ	PROMOTIONAL PRICE £	REIMBURSEMENT PRICE £	PIP CODE
Glucosamine PDP 1500mg Tablets	30	1	4.89	24.86	333-0040
Glucosamine PDP 750mg Tablets	30	1	3.98	19.86	333-0073
Glucosamine PDP 500mg Tablets	90	1	4.89	24.86	333-0065
Glucosamine PDP 500mg Capsules	90	1	4.89	24.86	333-0032
Glucosamine/Chondroitin PDP Combi 500/400mg Tablets	30	1	6.75	24.86	333-0057

Available from your AAH, PHOENIX, MALTBY, and UNICHEM Wholesalers

* CLASSIFICATION: Food Supplement – NOT a Licensed Pharmaceutical

Shouldn't primary care be pharmacist-led?

Primary care should be nurse-led, according to a professor of health services research writing in last week's BMJ. And I would be branded a traitor if I agreed.

Have fun interchanging the words, 'pharmacist', 'doctor/general practitioner' and 'nurse' in the professor's article:

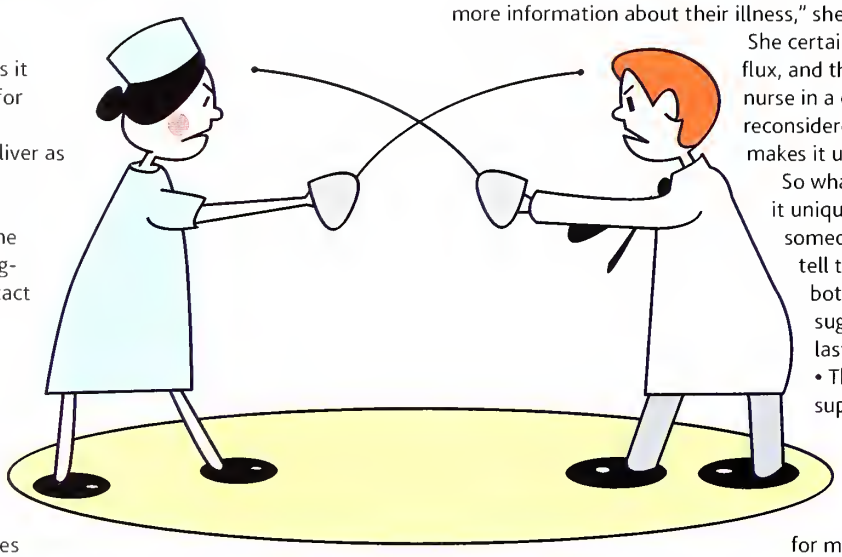
"Nurses and doctors have overlapping skills, which makes it possible for one to substitute for the other."

"Primary care nurses can deliver as high quality care as general practitioners in the areas of preventative healthcare, routine follow-up of patients with long-term conditions, and first contact care for people with minor illness."

"Too often, general practitioners continue to provide the same services as nurses, leading to duplication."

Switching the word 'nurse' for the word 'pharmacist' makes this article sound suspiciously like elements of the pharmacy white paper, the pharmacy plan, and most other recent visionary government documents on pharmacy. Everyone seems more confused about the difference between a nurse and a pharmacist than that between a nurse and a doctor, and a pharmacist and a doctor.

The counter argument is not proposed by a pharmacist of course, but by a GP who insists that, while nurses are terrific and extremely useful, they shouldn't be allowed to get ideas above their station. The GP cites the last nurse she's aware of who deserved respect: Florence Nightingale.



The lady with the lamp showed skill in "leadership, evidence based healthcare and nursing transformed healthcare" but she's no threat to GPs because she's dead.

But is this GP really talking about pharmacists?

"Patients were generally more satisfied with nurses, reporting receiving more information about their illness," she says.

She certainly is here: "Nursing is in flux, and the role and training of the nurse in a changing climate is being reconsidered. What is nursing and what makes it unique?"

So what is pharmacy and what makes it unique? (that's my question). I wish someone would write to the BMJ and tell them. But in case nobody bothers, I borrowed a few suggestions of my own from last week's C+D:

- The manager of the local superstore can tell pharmacists how to carry out their clinical role.
- Pharmacists won't have a proper professional body for much longer.
- The whole basis on which individual pharmacists invested in their own businesses is about to be turned upside down as control of entry "falls away".

Even if you're struggling to find something to be proud of in your profession, there's plenty to be loud about. The sheer injustice of it all, for a start. How dare we be confused with nurses? We must be more special because there are fewer of us, we've got our own smashing coat of arms, we don't have to touch naked bodies and we know all about drugs. Why does nobody believe me?

Pharmacist in the House — Sandra Gidley

Cry freedom for expression and speech

I usually try not to mention party politics, but this month I think it's worth starting by pointing out that the reason I joined the Liberal Democrats was because I greatly value freedom of speech and freedom of expression. These have always been at the heart of Lib Dem thinking.

So, you can imagine my discomfort when I read about Paul Badham, who has been reprimanded by the Society because of his stance against the slaughter of goats (C+D, August 16, p6). It appears that a member of the public objected to his window display. I can only speculate as to why that member of the public did not make their feelings known to Mr Badham directly and then take her business elsewhere. Why did she bring the matter to the attention of the Pharm Soc?

The whole sorry episode has prompted me to review my past life, working as a pharmacist. I confess that on one day during the 1992 General Election I wore a Lib Dem lapel badge. Now, some people probably feel the same way about Liberal Dems as one lady felt about the goat protest, but I struggle to see what the problem is. Personally, I think it is more offensive to see a tatty, run down pharmacy.

The problem is that the regulatory body is now able to take into account something called "attitudes and behaviours". I queried this when I saw it in the Section 60 Order as it had a "Stepford Wives" connotation. I was assured that this would be used on rare occasions. For example, a student might exhibit a range of behaviours that gave rise to concerns about future fitness to practise and this would give the Society the powers to deal with the problem. At the time it seemed a reasonable enough argument.

The goats have got me wondering what will be next? Do we want pharmacists to be so bland that they are not allowed to express an opinion, display a protest poster or collect petition signatures? It may sound far fetched, but an objection to a petition is not too far removed from an objection about goats.

We are told that the new regulator will be 'light touch', but I have yet to understand what that means in practice. By all means ensure patients are safe but let's make sure we are not introducing a new kind of pharmacy robot.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

TENA *Pants*.

Are you stocking the brand leader?

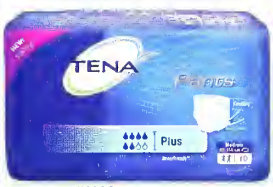
- **TENA** accounts for 81% of UK retail sales of incontinence products[1]
- **TENA *Pants*** products dominate their market sector
- Sales of **TENA *Pants*** have grown by 32.9%[2]
- The UK's ageing population means exceptional growth potential for **TENA *Pants***

[1] Source: IRI 52 w/e August 9 2008 Total Market Value Share
[2] Source: IRI 52 w/e August 9 2008 Total Volume Sales

TENA

www.tena.co.uk

TENA *Pants* Discreet



TENA *Pants* Plus

TENA *Pants* Super

TENA. The UK's No.1

UK sales of bladder weakness products 2008

81%	TENA
6%	DEPEND
4%	ENVIVE

% TOTAL UK MARKET (Source: IRI 52 w/e August 9 2008 Total Market Value Share)

Greater security for your customers greater sales potential for you.

Product	Size	Pip code	Box contents
TENA *Pants* Discreet	M	313-0945	4 x 8 (32)
TENA *Pants* Discreet	L	313-0952	4 x 7 (28)
TENA *Pants* Discreet	M	283-2327	4 x 12 (48)
TENA *Pants* Discreet	L	283-2343	4 x 10 (40)
TENA *Pants* Plus	XS†	293-6425	4 x 11 (44)
TENA *Pants* Plus	S†	220-9864	4 x 14 (56)
TENA *Pants* Plus	M	220-9872	4 x 10 (40)
TENA *Pants* Plus	L	220-9880	4 x 8 (32)
TENA *Pants* Plus	XL	317-5064	4 x 12 (48)
TENA *Pants* Super	S†	317-5056	4 x 12 (48)
TENA *Pants* Super	M	296-6273	4 x 12 (48)
TENA *Pants* Super	L	296-6281	4 x 12 (48)

†Product suitable for older children/small adults. Packaging of this particular size may vary from the item shown.

FREE Pharmacy sample bag

For your FREE TENA sample bag* containing all 70 TENA products, please contact the TENA Pharmacy Helpline on 0870 333 0874 quoting: CDP0908P.

*Due to the increasing number of sample bag requests, it is now necessary to limit them to one per pharmacy per year. TENA is a registered trademark of SCA Hygiene Products UK Ltd

Letters

Please email us with your letters including your name and contact number to: **haveyoursay@cmpmedica.com**

Or write to the Editor at:

C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Letters may be edited for content and length

Don't take the sugar-coated bitter pill, urges buying group

Is the government's pharmacy white paper (Pharmacy in England: Building on strengths – delivering the future) a bitter pill for the profession coated in sugar?

The first piece of work to emerge from the white paper is something pharmacy would least welcome. It is a consultation on proposals for legislative change, which we feel will lead to the relaxation of control of entry.

When the white paper explicitly states that access to community pharmacies is very good, why does the consultation suggest that the current arrangements do not give PCTs enough power to commission pharmacy services? If access is so good, where is the problem?

Perhaps access is good because PCTs only have limited scope to meddle? Would it not be more beneficial for PCTs to concentrate their limited resources on improving access to GP and dental services, which are a problem?

We are told that the proposed changes to control of entry will enable the development of new pharmacy services. However, pharmacy does not need a change in control of entry to fulfil its potential. Surely the DH would do better to explicitly direct PCTs, which are dominated by GPs and managers who lack pharmacy knowledge, to ensure a level playing field for all providers when it comes to commissioning services.

The consultation also talks about improving the quality of services – again does this need a reform of control of entry? By all means let's have quality at the heart of services but why change control of entry yet again?

Do pharmacists feel their PCT will conduct appropriate pharmaceutical needs assessments (PNA)? And then make appropriate decisions based on these PNAs? Have pharmacists seen their PCTs' current PNA?

Pharmacy needs to take urgent action – this bitter pill does not have to be ingested. We believe all pharmacists should:

- attend the 'listening events' being organised by Primary Care Contracting (PCC). Feedback from these events seems to have strongly influenced the consultation and is quoted on many occasions within it. However, the majority of attendees were PCT managers. Dispensing doctors also attended in good numbers. There were very few community pharmacists. It is well worth investing in a day's locum to attend these events.
- respond to the consultation as every response counts. True, the national pharmacy bodies will respond but that will only count as one response each.
- ask your patients to respond. The key questions are on pages 21 and 27. Help them compose answers in their own words. Ask them to lobby their MP. If each pharmacy asked just four people to respond along with each pharmacy, it would mean over 50,000 responses.
- lobby your MP. C+D has done a great favour to pharmacy with its campaign of engagement with local MPs. More pharmacists need to get on board. Those who have already seen their MP need to ask for their support in this campaign.

The last time pharmacy got together it managed to successfully avoid the full impact of the OFT's proposals. Similar widespread action is now required again – otherwise this sugar-coated bitter pill may be the last thing pharmacy ingests.

Shafique Govani, head of Beta Buying Group, Witham, Essex (the group represents over 200 independent community pharmacies)

On MAS

It is about time pharmacies all stand united to get a fairer deal on matters like the minor ailments fiasco (C+D, August 30, p10). Long may this collaboration between the big names in pharmacy and the PCC continue. All pharmacies should be urged to support PCC and stand by their directions.

Richard Sherwood MPSNI MRPharmS

Drive-through pharmacy benefits customers

Boots is to be congratulated on the opening of its first drive-through pharmacy (C+D, August 30, p6), the second such pharmacy in the UK.

The first was established in 2001 by Munro which, following acquisition, was rebranded as Lloydspharmacy in April.

The drive-through concept is just one way in which pharmacy is innovating for the benefit of customers. For example, at Lloydspharmacy we are trialling a wide range of initiatives to reduce customer waiting times and we've also launched a web-based diagnosis and prescription service in conjunction with the online GP Dr Thom.

Added to that, of course, thousands of pharmacies have invested in private consultation areas and in the training and infrastructure required to support easy-to-access screening and diagnostic services.

Surely no healthcare sector is making greater efforts than pharmacy to reorganise its services around the needs of customers?

Steve Gray, operations director, Lloydspharmacy

Working together to prepare for EPS – are you doing your bit?

In response to Peter McAuley's question "Has anyone really thought about how EPS will work?" (C+D, August 23, p10), the simple answer is yes.

Connecting for Health (CfH) has for many years actively consulted representatives of the pharmacy profession (myself included), the medical profession, appliance contractors and patient groups to deliver a service that is efficient, practical and user-friendly.

I would not pretend that all the problems have been solved; this is after all a system that is under development and there will no doubt be challenges in the future. Let me reassure Mr McAuley, however, that many people have for some time been trying to anticipate these challenges and thinking really hard about how EPS will work in practice.

Release 1 allows pharmacists and their teams to experience how EPS works, to identify the problems that need to be fed back to their system supplier and to plan how they will need to work differently in the future. Those pharmacies not receiving barcoded prescriptions are being severely disadvantaged and they should be beating down the doors of their local surgeries to request that they switch on release 1 functionality. Any refusal to do so should be referred to the local PCT to resolve.

It is in our collective interests to ensure that when release 2 is implemented we are using systems that are fit for purpose. How EPS works within practice is largely for the profession itself to determine. System suppliers live in a competitive world and the most successful will be the ones that provide the best solutions to address the needs of pharmacy. Release 2 will see the biggest paradigm shift for pharmacy since the start of the NHS and the profession needs to shape how we are going to work in the future. Only by actively using EPS, identifying problems and working collaboratively with system suppliers to correct them do we stand any chance of getting what we actually want.

Will we need to print out prescriptions or tokens to capture exemption status? Yes of course we will, at least until alternative technical solutions are implemented. Will this be onerous, take time and add to pharmacy workload? No, not if the system is set up correctly; the printing will occur automatically as it would in any well designed system.

Will we need a second terminal to check prescriptions against? Well it's one model but there are others. Personally, at least to begin with, I will still want a piece of paper to check against but I know others have different views. But actually a second terminal is not going to be anywhere near enough to deliver a professional pharmacy service in the future. We need a fully integrated and networked system with workstations in the dispensary, the consulting rooms and on the front counter that can capture data and access information swiftly, intelligently and seamlessly. How it is funded is a question for PSNC and DH.

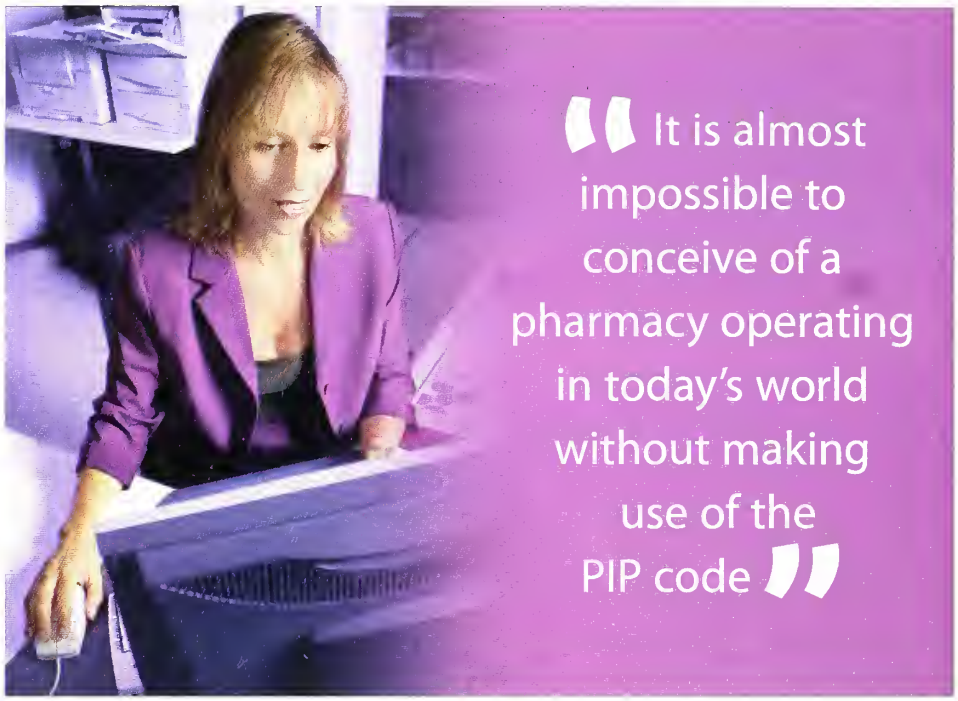
To return to the initial question, "Has anyone really thought about how EPS will work?", the answer remains a resounding yes. My biggest concern however is that not enough of the profession is currently doing so.

Patrick Leppard, service development lead for Hampshire & Isle of Wight LPC and a member of Connecting for Health's EPS community pharmacy user group

EPS: friend or foe?
haveyoursay@cmpmedica.com

Paying for the PIP code

C+D is about to launch a campaign to ensure all those who benefit from the PIP code contribute to the costs of maintaining it. C+D publisher **Phil Johnson** explains



What is the PIP code?

The PIP code is a unique coding system designed to allow the identification and efficient ordering of products sold by UK pharmacies. Currently it consists of a seven-digit number plus the brand, strength, form, quantity, trade unit, retail unit, flavour and colour. While its origins date back much further, the code came into widespread use in the 1980s after its scope was developed by the NPA and it is now used throughout the pharmacy supply chain. You will see it published in wholesalers' product lists and, although you may not be aware, it will be found deep within your dispensary computer system. You will also see it in the C+D Monthly Price List.

Who looks after the PIP code?

The PIP code is managed on behalf of the industry by CMPMedica, the publishers of Chemist+Druggist, with input from the NPA via the PIP code panel, which it organises. It is C+D that pays for the database which holds the code and for the staff who input and maintain information on the 80,000 products in the file and process some 26,000 changes each year. It is also C+D that arranges the distribution of the PIP code via electronic files (sent each week to system suppliers and wholesalers), via the Monthly Price List and weekly updates (sent to C+D subscribers) and via the C+D Data website.

Who owns the PIP code?

In 1982, the NPA and the publishers of C+D signed an agreement to share the copyright in the PIP code between them. This means pharmacies require two licences – one from the NPA and one from C+D. The first is provided as part of NPA membership, the second by a C+D subscription (see NPA/C+D joint statement at http://tinyurl.com/6lkdne for more details).

How is the PIP code funded?

C+D makes a nominal charge to system suppliers and wholesalers to cover the cost of supplying regular electronic updates of its data (which then appear in pharmacy computer systems and in product lists), but the true cost of maintaining the PIP code has always been funded by pharmacies via the subscription they pay for C+D. In addition, the NPA licenses – and collects revenue from – non-pharmacy users of the code.

What does that mean to me?

While the vast majority of pharmacies have a subscription to C+D, a small number do not. This means they are not contributing to the cost of maintaining the PIP code, which is unfair on those who do. C+D is therefore, with the support of the NPA, contacting all pharmacies without a subscription and drawing the situation to their attention. These pharmacies will be expected to take out a subscription.

Do all pharmacies have to pay?

It is almost impossible to conceive of a pharmacy operating in today's world without making use of the PIP code to order at least some product lines. The assumption of C+D and the NPA is therefore that all pharmacies should have both membership of the association and a subscription to C+D unless they can demonstrate otherwise. The cost to pharmacies is picked up by the cost inquiries carried out by PSNC and Community Pharmacy Scotland and forms part of the negotiations on cost reimbursement via the pharmacy contracts.

What is the NPA's view?

Funding of the PIP code was discussed at the NPA Board meeting in July 2008 and NPA chairman Paul Bennett afterwards released the following statement: "The NPA and CMPMedica are partners in the PIP code project that provides the data backbone to much of the electronic communication in pharmacy systems.

"This Board believes the benefit of having a single dataset for pharmacy electronic communications is an asset to be coveted in which pharmacy should invest.

"We are aware that recent changes in the structure and pricing by CMPMedica have caused concern amongst NPA members. I have therefore asked the NPA to work in partnership with CMPMedica to improve communication of the changes and benefits of this important project to NPA members."

NPA chief executive John Turk added: "The PIP code has served everyone in the community pharmacy supply chain well since its inception. It is an important principle that everyone who benefits from it contributes to its upkeep."

What should I do if I don't currently subscribe?

We will shortly be contacting you to explain the various subscription options available. Just choose the best option for you and return the completed form along with payment.

Alternatively you can contact our subscription hotline on **01858 438809**.

PIP code factfile

- **The PIP code consists of a seven-digit number, brand, strength, form, quantity, trade/retail unit, flavour and colour**
- **80,000 products on file**
- **26,000 changes each year**
- **Updated weekly**
- **Funded via subscription to C+D**

NICE[1] focus on IBS

hyoscine butylbromide

Now is the time to focus on IBS relief. Because NICE[1] has now recognised the essential role of self-care in managing IBS – your recommendation can make all the difference. Buscopan® IBS Relief is the same effective antispasmodic as always, providing targeted relief of abdominal cramps, pain and discomfort. But now it has a striking new

New design. Trusted IBS relief.

design, to help you guide sufferers towards tried and trusted IBS relief.* To find out more, visit www.buscopan.co.uk and www.nice.org.uk

*For medically confirmed IBS

Buscopan® IBS Relief – Product Information
Tablets containing hyoscine butylbromide 10mg **Indication:** Relief of gastro-intestinal tract spasm associated with medically confirmed irritable bowel syndrome. **Dose:** *adults (over 12 years) only:* initially 1 tablet three times daily, increasing if necessary to 2 tablets four times a day. **Contra-indications:** myasthenia gravis, megacolon, narrow angle glaucoma, known hypersensitivity to any component. **Warnings and precautions:** conditions characterised by tachycardia, those susceptible to intestinal or urinary outlet obstruction, pyrexia. Warn patients to seek medical advice if they develop a painful red eye with loss of vision whilst or after taking Buscopan IBS Relief. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take Buscopan IBS Relief since the tablet coat contains sucrose. Advise patients to consult their doctor before taking IBS Relief if age over 40 years and some time since the last attack of IBS or the symptoms are different, recent rectal bleeding; severe constipation; nausea or vomiting, loss of appetite or weight, difficulty or pain passing urine; fever, recent travel abroad. Advise patients to consult their doctor if they develop new symptoms, or if symptoms worsen, or if they do not improve after 2 weeks of treatment. **Interactions:** Co-administration with a dopamine antagonist may diminish the effect of both medicines. **Undesirable effects:** dry mouth, tachycardia, hypersensitivity, skin reactions. *Rare:* urinary retention; dyshidrosis, isolated cases of anaphylaxis with episodes of dyspnoea and shock. **Pack size and retail price:** 20 tablets £4.39. PL 00015/0253. **Legal category:** GSL. **Product Licence Holder:** Boehringer Ingelheim Ltd., Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. For fuller information please see Summary of Product Characteristics. Prepared in August 2006

Boehringer Ingelheim

Reference 1 Irritable bowel syndrome. NICE guideline, NICE clinical guideline 61, February 2008

Date of preparation: August 2008

Fact: New clinical proof that a 10 minute head lice treatment time* is effective[1]

- Clinically proven to kill head lice
- 10 minute treatment time*
- Easy to apply to scalp and hair
- No traditional pesticides means no resistance
- Value for money – comb included in pack

headlice.co.uk

1. Burgess IF, Brown CM, Lee PN. Randomised, controlled, single, parallel group clinical trials to demonstrate the efficacy of isopropyl myristate/cyclomethicone solution (Full Marks Solution) against head lice. Pharm Jnl 2008; 280: 371-375.
*10 minute treatment time refers to two applications, seven days apart.

SSL International, Venus, 1 Old Park Lane, Trafford Park, Manchester M41 7HA, UK.

C+D Clinical

Protecting patients

The second article in a series on ethics discusses pharmacists' duty of care when monitoring repeats and working with professionals whose decisions might be at fault

Key points

- A pharmacist's duty of care extends to taking steps to limit overprescribing for individual patients.
- Pharmacists should be prepared to challenge other health professionals whose decisions appear to compromise patient safety.
- Whistle blowing may be necessary in the interests of patients.
- Pharmacists may be implicated in manslaughter cases if patients die from the adverse effects of medication.

Joy Wingfield FRPharmS

Reflect

Should you always check whether patients are requesting repeats for unnecessary items? Should you keep a record of all interventions? How insistent should you be when querying with a GP a possible error on a prescription?

Plan

This article covers the ethical issues at stake for repeat dispensing and when another health professional's decision may be at fault.

CPD This article can help in the following CPD competencies: **G1a, G1k, G1m, G1t, G5h, G5j, C4j.** See http://tinyurl.com/68ox7b

Most community pharmacists have little difficulty in identifying that their primary duty of care is to protect the patient's interest. In at least one civil court case[1], this includes recognising potential risks on a prescription and intervening to prevent harm.

In a second case[2], the Royal Pharmaceutical Society's disciplinary committee reprimanded pharmacist Mr S for dispensing medicines that had inadvertently been prescribed in excessive quantities on repeat prescriptions. The committee found that the duty of care in such cases is that pharmacists may need to monitor and question the appropriateness of repeats, and go on challenging them if a patient may be at risk. Ultimately, the pharmacist, Mr S, was reprimanded only for dispensing one of three medicines – Didronel PMO – that had been prescribed too often, but the transcript[3] of the decision effectively spells out some of the standards of care that are likely to apply when dealing with repeats. For example, Mr S accepted that he had not actually spoken to any of the three prescribing doctors and that he had made an error of judgement "in not insisting on speaking with the doctor".

The committee chairman declared that "the pharmacist's duty to check prescriptions and resolve queries with the prescriber is an important one for the protection of the patient". He also noted that Mr S had

Protecting the patient's interest includes recognising potential risks on a prescription and intervening to prevent harm

continued to supply Didronel PMO while aware that the amount was excessive; in other words the pharmacist had a duty to monitor frequency and quantities on repeat prescriptions to prevent harm.

Cases involving the duty of care in dispensing come quite rarely to disciplinary notice. The 'charge' was based on the pre-2007 Code of Ethics but the phrases concerning patient care and patients' interests are closely replicated in the current code. Moreover, the expectation that pharmacists will monitor and query repeat prescriptions appears in some detail in both the earlier code and in the current Code of Ethics (see panel 1, right). So perhaps there is nothing unexpected in these aspects of the committee's ruling.

Of more interest is the reference to direct contact with the prescribing doctors. All three doctors freely admitted that there had been insufficient checking on their part when the prescriptions were signed and that the quantities were excessive. The pharmacist had left messages with the surgery staff but they seemed "unconcerned" and took no action. The pharmacist had "also visited the surgery on numerous occasions, as had his assistant, to collect prescriptions for the patient in question but had not asked, attempted or seen the doctors regarding these matters".

Professional autonomy

One of the now discredited concepts of professionalism is that of total professional autonomy.[4] In the past this has led to a climate where a health professional, usually a doctor, has been able to continue to cause harm to patients because colleagues and associates felt unable to challenge their practice or judgement (for example in the Kennedy Inquiry into Bristol hospitals and the Shipman Inquiry).

A modern interpretation of professional autonomy now raises expectations that all health professionals, including pharmacists, should be more active in pursuing such concerns. The current Code of Ethics (paragraph 2.4) makes this explicit: "Be prepared to challenge the judgement of colleagues and other health and social care professionals if you have reason to believe that their decisions could compromise the safety and care of others."

A recent paper[5] has suggested that some of the ethical anxiety experienced by community pharmacists arises from decisions on "whether to challenge doctors' prescribing when a clinical problem or error has been identified". The paper continues: "In such examples, the welfare and best interests of the patient conflicted not with a legal concern, but with autonomy of healthcare professionals and the welfare of the patient. Pharmacists' subordination to doctors appeared to be evident in such ethical problems..." In the case of Mr S, the committee accepted that the repeat prescriptions were perfectly legal; nevertheless they concluded that his dispensing was "seriously deficient". That deficiency could be because he was so detached from the patient care team – GPs and surgery staff – that his attempts to assert his professional judgement and autonomy were brushed aside.

PANEL 1: RPSGB STANDARDS FOR REPEAT MEDICATION SERVICES*

A repeat medication service is a service operated in co-operation with local prescribers, in which pharmacists will provide professional support to assist in the rational, safe, effective and economic use of medicines. To provide a repeat medication service, you must:

- Ensure the pharmacy operates a patient medication record system notified to the Information Commissioner's Office.
- Ensure that an audit trail exists to identify each request and supply.
- Establish, at the time of the request, which items the patient or carer considers are required and ensure that unnecessary supplies are not made. At this stage pharmacists must also use their professional judgement to decide whether concordance or other problems encountered by the patient may require early reference to the prescriber.
- Not request a repeat prescription from a surgery before obtaining the patient's or carer's consent. You may, however, institute a patient reminder system.
- Record all interventions in order to be able to deal with any queries that arise.

* RPSGB Code of Ethics. Professional standards and guidance for sale and supply of medicines.

Duty of care

Thus the nature of the community pharmacist's duty of care has been extended; from intervention to prevent obvious harm, through a judgement on clinical appropriateness to taking decisive and persistent steps to limit over-prescribing and secure a positive outcome for the patient. Some observers may have privately thought the pharmacist did as much as he could, and that they would have done the same and so would most pharmacists. Indeed, had there been harm to the patient and had the case come to the civil courts before this disciplinary case, the outcome might have been different.

The courts use the Bolam test to establish whether the duty of care exercised in the matter under investigation is accepted as proper in the opinion[6] of a responsible body of fellow practitioners. Expert witnesses are then used to give evidence as to what duty of care should have been applied. They might have said that the pharmacist had already done enough by raising concerns with the surgery.

However, in the light of the latest requirements in the Code of Ethics and in the Mr S case, expectations have now risen.

Other developments imply that community pharmacists should anticipate more demanding expectations of their duty of care in relation to medicines supply. At a recent conference[7], a coroner expressed the view that as pharmacists are taking over roles from GPs, their role in deaths from medicines would come under scrutiny. He suggested pharmacists would need to pay meticulous attention to records[8] of their interventions, phone calls and identity checks to avoid accusations of failing to prevent the adverse effects of prescribed medicines.

Inclusion of pharmacists in coroner's inquiries is now more common. One was reported earlier this year[9] and the Pharmacists' Defence Association indicated at their 2008 conference that they are now involved in several cases where pharmacists have been implicated in manslaughter cases following "deaths associated with medication".

Vulnerable patients

As well as prescriptions for individual patients, there are signs that the pharmacist's duty of care is rising towards groups of patients, specifically those with dementia in care homes.

Just about every health and social care profession came in for criticism in a recent report by the Alzheimer's Society[10,11,12], but the recommendations concerning prescribing, monitoring and review of antipsychotic medication have particular resonance for community pharmacists. Observers such as the charity For Dementia have already suggested[13] that community pharmacists are best placed to carry out monitoring and review of care home medication. As ever, such recognition of their expertise and potential is welcome, but at what point will failure to carry out such checks become a failure of duty of care to these patients?

In care homes, where most medicine supply is on repeat prescriptions, pharmacists employed by the inspection authority[14] look for evidence that policies and procedures ensure that medicines are not hoarded because of over-prescribing. However, anecdotal reports[15] suggest that community pharmacists are failing to prevent the accumulation of, for example, 12 months' supply of inhalers, 10 months' worth of warfarin tablets and 500 co-codamol tablets each for a single patient. If Mr S has failed in his duty of care to prevent over-prescribing for one patient, then surely the same standards may soon

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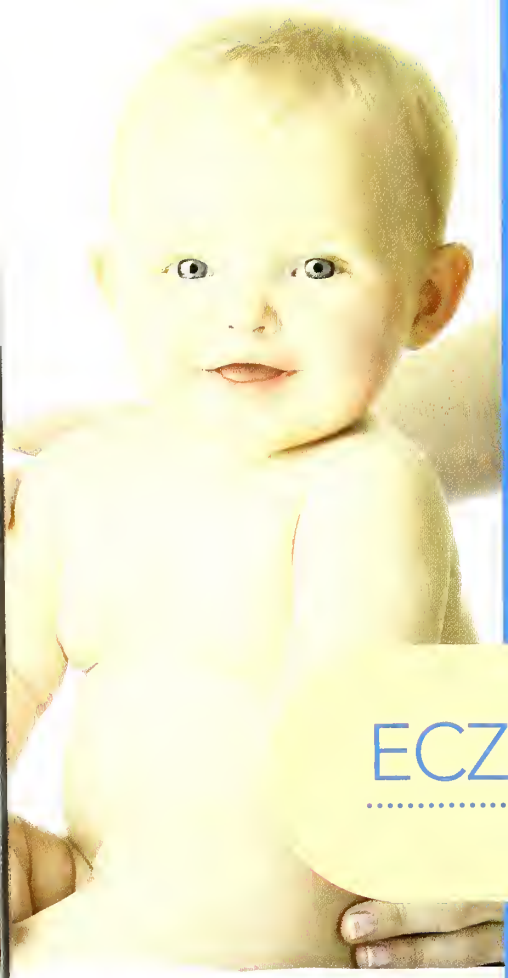

C+D Guide to Eczema

ECZEMA

In this C+D guide to ECZEMA:

- What triggers atopic eczema?
- What happens when skin is affected by eczema
- How emollients work to help re-hydrate the skin
- Good practice points for patients

- Emollients are recognised as being the most important treatment for atopic eczema, particularly in children under 12,[1] but in practice they are often used ineffectively and the full benefits are not achieved[2].

- The importance of choosing the right emollient products is not always understood – all emollients are not the same and choosing appropriate products can have a significant influence on the outcome of treatment.

- Pharmacists can educate patients and parents about appropriate use of emollients and to reinforce good practice. Important points to reinforce are the routine use of an emollient wash product instead of soap or detergents, and the need to continue emollient treatment when the skin is in good condition and during a flare-up when treatment is stepped up.

C+D Guide to ECZEMA

Atopic eczema and effective emollient use

Atopic eczema now affects over 20 per cent of children in the UK at some stage in their childhood[1]. The prevalence of atopic eczema – the type often associated with asthma and allergic rhinitis – has increased considerably over the past 30 years[4]. All types of eczema result in red, itchy, sore, inflamed skin. Chronic eczema can lead to patches of thickened, dry, leathery skin as a result of repeated rubbing and scratching.

Recent research suggests that people with atopic eczema have a genetic predisposition to a weakened skin barrier and this makes them more sensitive to some triggers than people who do not have eczema[5].

The past 20 years have seen a significant increase in the exposure to skin of soap and surfactant products, in conjunction with a rise in the frequency of bathing and showering[9]. Soap and detergents (shampoo, washing-up liquid) can trigger eczema by removing skin lipids and damaging the skin barrier. Washing with soap, for example, reduces the thickness of the stratum corneum of normal individuals and those with atopic eczema[6].

Other environmental factors also play a role. House dust mite is associated with atopic eczema[6] and this has increased in recent years along with central heating and carpeted bedrooms. Other airborne allergens such as animal dander and pollen can also contribute. Non-allergic causes such as rough fabrics, extremes of temperature and humidity and colonisation of the skin by Staphylococcus aureus can also trigger flare ups[4].

Understanding the skin barrier function

The skin barrier prevents excessive water loss from the skin and underlying tissues and prevents the entry of irritants and infective agents. Several elements of the stratum corneum (the uppermost layer of the epidermis) form the skin barrier. In healthy individuals the corneocytes (skin cells) are packed tightly together and are surrounded by a layer of lipids (the lipid lamellae). This is analogous to a brick wall where cells are the bricks and the lipid lamellae is the waterproofing mortar.

Natural moisturising factor – a mixture of substances including urea and amino acids – inside the corneocytes attracts water and keeps the cells swollen and pressed together. In addition the cells are linked to each other by corneodesmosomes (protein bridges). All these elements together make up the skin barrier.

Normally water loss from the skin is kept to a minimum and the skin is naturally elastic and pliable. However, water loss increases when the skin barrier is damaged. In atopic eczema a number of changes occur (including changes in the lamellar lipids) which result in a defective or weakened skin barrier[7]. In consequence water is lost from the stratum corneum and a series of events is set in train.

As water is lost, the corneocytes shrink and gaps open up between the cells. The skin barrier is further weakened, irritants and allergens can enter and the skin becomes inflamed. At this stage itching leads to scratching, which causes further inflammation and more itching – and the characteristic lesions of eczema appear.

Repairing the skin with emollients

An emollient forms a fine oily layer over the skin that prevents the evaporation of water. The water trapped in the stratum corneum passes into the corneocytes, which swell and close up intercellular gaps. In addition, emollients can penetrate the stratum corneum and mimic the barrier effects of the deficient lipids. These effects immediately reverse some of the changes that have occurred and restore the skin barrier. Although all emollients work in this way, some are more effective or pleasant to use than others. Moreover, some products contain additional ingredients to improve hydration or reduce itching that make them particularly useful.

Types of emollient

Emollient creams are oil-in-water emulsions designed to be left on the skin. The water phase evaporates and leaves a fine film of oil. Some are richer or oilier than others. They tend to rub off during wear and need to be reapplied frequently.

Bath oils are dispersible oils that are added to bath water. They form a layer of oil on the skin as they patient leaves the water and some can be used for washing. They do not form a lather but contain sufficient mild surfactant to remove sweat and grime from skin.

Emollient wash products are designed for use as soap-substitutes. They contain emollients and mild surfactants; they feel creamy to use and can be rinsed with water.

A key ingredient of some emollients is lanolin, which is an excellent emollient and, contrary to popular belief, is not highly allergenic. Modern emollients use highly-purified lanolin which is very rarely a cause of allergy[8]. Some emollients contain humectants (water-attracting agents) such as urea which help to increase hydration of the stratum corneum yet further.

Anti-itch ingredients such as lauromacrogols are added to some emollient products. Perfumes and preservatives can sometimes cause allergic reactions and so unperfumed emollients are recommended for children[1].

Aqueous cream was originally designed as a wash product rather than as a leave-on emollient and a 2003 study has shown that it is associated with a high incidence of adverse reactions in children[2]. It should not be recommended as a first-line leave-on emollient in children[1]. ▶

Complete emollient therapy

'Complete emollient therapy' is often recommended by dermatologists[1]. This involves avoiding soap and detergents as far as possible and frequent use of emollients. In practice this means regular use of emollient creams or ointments, the use of a bath oil when bathing or showering, and the use of an emollient soap substitute for hand and body washing.

It is particularly important not to undo benefits of emollients by using soap and detergents for washing. Emollients should be applied frequently to keep the skin supple and pliable and for some areas of the body this could be four or five times a day. They should be smoothed on quickly and gently, working in the direction of hair growth[1].

Flare-ups

A flare-up of eczema is characterised by increased dryness, itching, redness, swelling of the skin and, in an infant, general irritability. It can be triggered by exposure to an irritant, such as soap, detergents or rough fabrics, or by exposure to an allergen such as house dust mite, animal dander or pollen. If there is an obvious trigger then it makes sense to avoid it if possible or take steps to reduce exposure.

It is important to recognise a flare-up and start treatment immediately. The NICE guidelines in children[1] recommend following a stepped care plan. This involves stepping up treatment by adding a suitable topical corticosteroid to treatment. Topical corticosteroids reduce inflammation and help to reduce itching and break itch-scratch cycle.

It is important to continue to use the emollient as well as the topical corticosteroid – although patients might need to switch to richer (higher lipid) product and increase frequency. Another useful measure is to use an emollient that contains lauromacrogols, which have an anti-itch action. Treatment should continue for about 48 hours after symptoms subside and then be stepped down to emollients alone. Infected eczema can cause rapid deterioration of the skin and if suspected should always be referred to a doctor.

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be applied to supplies of medicines to care homes and facilities such as prisons and children's homes, or even patients who are housebound.

Mitigating the risks

It is easy to view the rising burden of duty of care with alarm but there are some reassurances and steps that might be taken to mitigate the increasing risks.

Firstly, the standard of duty of care will match that prevalent in pharmacy practice at the time and will not necessarily be that of the "perfect practitioner". Standards in official publications such as the Code of Ethics used for disciplinary purposes should usually represent the minimum acceptable. Generalist practice will be judged against that of other generalists but pharmacists at the "leading edge" who deliver more than the minimum will create pressure to raise the minimum standard. The duty of care, say, of a Pharmacist with a Special Interest in the care of the elderly, would be higher than, say, that of a locum providing temporary cover in a high street pharmacy.

We are used to hearing that community pharmacists are often left out of the NHS 'family', with calls for greater recognition of their contribution to teamwork and mutual understanding of different professional roles in the optimising of patient care, but the above account indicates that acceptance of such lack of recognition can create risks. Questions such as "Where was the pharmacist in this process?" and "Why was the pharmacist who supplied these medicines not preventing this problem or harm?" are a natural consequence of claiming greater professional input into the supply process.

The Code of Ethics now makes an explicit obligation on pharmacists to promote and contribute to the effectiveness of healthcare teams (see panel 2). Community pharmacists might wish to check the robustness of their own working arrangements and redouble efforts, perhaps using their pharmacy technicians, to prevent over-prescribing and accumulation of medicines in the patient's own home or within care homes.

Many pharmacists already have good working relationships with their local surgeries and GPs but what if, despite all efforts, patients remain at risk because no corrective action is taken? Here the Code of Ethics says the pharmacist's duty (see again panel 2) is to be a "whistle blower", to speak out on the patient's behalf and become the patient's champion, if necessary. The concept of whistle blowing is relatively new but the Society has produced comprehensive guidance[16] to assist practising pharmacists.

For community pharmacists to maintain good working relationships with prescribers while being prepared to challenge their perceived authority can be a tall order in some circumstances.

But asserting justified professional autonomy is an essential part of pharmacy professionalism; failure to do so may not just put patient care at risk, it may also jeopardise the future of the practising pharmacist.

PANEL 2: EXTRACTS FROM THE RPSGB CODE OF ETHICS ON RESPONSIBILITY

Team working is a key feature of everyday professional practice and requires respect, co-operation and communication with colleagues from your own and other professions. When working as part of a team you remain accountable for your own decisions, behaviour and any work done under your supervision. You must:

- Communicate and work effectively with colleagues from your own and other professions and ensure that both you and those you employ or supervise have sufficient language competence to do this.
- Contribute to the development, education and training of colleagues and students, sharing relevant knowledge, skills and expertise.
- Raise concerns if policies, systems, working conditions, or the actions, professional performance or health of others may compromise patient care or public safety. Take appropriate action if something goes wrong or others report concerns to you.

References and further reading are online at www.chemistanddruggist.co.uk/update

Joy Wingfield FRPharmS, MPhil, LLM, is a special professor of pharmacy law and ethics at Nottingham University, and founder of the Pharmacy Law and Ethics Association.

Your Continuing Professional Development

CPD

Act

- Read the RPSGB's Guidance on Recording Interventions at http://tinyurl.com/6mmnwd and think about how interventions are recorded in your pharmacy. Do other members of staff and locums know where the records are kept?
- Read the RPSGB's Raising Concerns – Guidance for Pharmacists and Registered Pharmacy Technicians at www.rpsgb.org/pdfs/raisingconcernsguid.pdf. This gives advice on what steps to take if you have concerns about another health professional.
- Think about your relationship with your local GP and other surgery staff; are there any steps you could take to make the intervention process easier?
- Refresh your memory by looking at the Code of Ethics and Professional Standards and Guidance section of the Medicines, Ethics and Practice Guide. Think about how you apply this in your work.

Evaluate

- Are you confident that you know and follow the correct procedures for repeat dispensing and interventions? Are you familiar with the Code of Ethics on these particular matters?

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the October 4 issue, which will cover this month's three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

Chemist+Druggist in association with Genus Pharmaceuticals

C+D GENUS PHARMACEUTICALS

A Practical Approach

Chloramphenicol drops sale

It is Saturday afternoon at the Update Pharmacy and relief pharmacist Lydia Allen is on duty.

A young woman asks to speak to the pharmacist. She hands Lydia a piece of paper on which is written 'kloramfenicol eye drops' and says: "I took this down over the phone. I hope I've spelled it right. I'd like a bottle please."

"Is this for you?" asks Lydia.

"No, it's for my daughter."

"How old is she?"

"Eighteen months."

"I'm afraid we can't sell it for children that young," Lydia says. "Who told you to get it?"

"The on-call doctor," the woman replies. "My daughter woke up with red eyes this morning and she kept rubbing them. I rinsed them with water but it didn't help, so I phoned my GP's number. They're closed today and the answerphone gave the deputising service number. I phoned and explained the situation and the operator put me through to a doctor.

"I described my daughter's symptoms and he said he thought she had conjunctivitis, but it wasn't serious and he didn't need to come out to see her. He told me to go to the chemist and get this."

"That's tricky," Lydia replies, "because we need a prescription before we can give it to you."

"But I must have it now," protests the woman. "My baby's really miserable with it. And I have to start treating her right away, because if I don't I'll have to stay at home with her and lose a day's work. Her nursery won't take her on Monday as it has a strict rule that you can't bring your child with an eye infection unless it has been treated with an antibiotic for at least 36 hours."

Lydia thinks to herself: "Can I do this as an emergency supply?"

Questions

1. What options, if any, does Lydia have to supply the chloramphenicol drops in this situation?

This article can help in the following CPD competencies: **G1a, G1d, G1h, G1j, G2o, C1f.** See http://tinyurl.com/68ox7b

Answers

1a) Lydia cannot make an emergency supply at the patient's request because the regulations allow only for supply of a medicine that has been previously prescribed.

b) Lydia could make the sale, knowing it was outside the licensing conditions but in the knowledge that it has been recommended by a doctor. However, in this situation responsibility for the supply would devolve upon Lydia, not the doctor, and she could be held to account if any problems resulted.

c) The best solution would be for Lydia to contact the deputising service and get a doctor to request an emergency supply over the telephone. This could be confirmed with a fax or email, but a valid prescription would still have to be sent within 72 hours.

C+D's A Practical Approach is supported by APOTEX UK LTD

LETHAL OBSESSION

Weight loss is a vital part of cardiovascular risk management and weight loss with Xenical can have a significant impact upon key risk factors.[1-5] When you help change their weight, you help change their future.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Roche Products Limited. Please contact Roche Drug Safety Centre on: 01707 367554

Roche **PRESCRIBING INFORMATION. XENICAL (orlistat). Indications:** XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug Interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue and gastrointestinal such as oily spotting, abdominal pain, increased defecation and flatulence. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. The incidence of adverse events decreased with prolonged use of orlistat. **Serious:** Very rare cases of increases in liver transaminases and alkaline phosphatase and also cases of hepatitis. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Rare hypersensitivity reactions of angioedema, bronchospasm and anaphylaxis. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg (84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** June 2007.

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Clinical News

Cancer link unclear

Evidence from a trial that prompted the FDA to investigate a possible link between treatment with simvastatin combined with eztimibe and increased risk of cancer has been called into doubt. A subsequent comment published by the New England Journal of Medicine suggested that signals of this kind from trials were difficult to interpret.
http://tinyurl.com/5c5way

Type 2 diabetes benefits

Data from the ADVANCE trial presented at the European Association for the Study of Diabetes is said to show that intensive sugar control combined with intensive blood pressure may reduce risk of death from heart disease by 24 per cent. The treatments used were modified-release gliclazide and a fixed combination of perindopril and indapamide; another benefit was a 33 per cent cut in kidney disease.
http://www.advance-trial.com

Chronic hand eczema treatment launched

Alitretinoin (Toctino) has been launched for the treatment of severe chronic hand eczema in adults by Basilea Pharmaceutica.

Indicated for use in patients with hand eczema unresponsive to topical corticosteroids, the treatment offers a new option for a group of patients disadvantaged by being unable to use their hands normally. The condition is frequently caused by a reaction to materials used in the course of the patient's work.

In a trial half of patients taking the treatment were said to have clear or almost clear hands at 24 weeks of treatment. The trial included patients unresponsive to conventional steroid treatment and who had suffered the condition for a minimum of nine years.

Alitretinoin is a naturally occurring vitamin A derivative. It is teratogenic and treatment of women of childbearing age should be limited to 30 days, and must be dispensed within seven days. See SPC for more details.
www.toctino.co.uk

Exenatide once a week 'effective'

A once-weekly formulation of the incretin mimetic exenatide has been shown to be at least as effective as twice-daily injections in a small trial published by The Lancet.

The study of 295 patients with type 2 diabetes showed significantly lower HbA_{1c} levels at the end of the 30-week trial in the arm treated with the weekly formulation, compared with those receiving the twice-daily dose.

Subjects receiving the weekly dose were also at no increased risk of hypoglycaemia, and showed similar reductions in body weight to the twice-daily treatment group.

Patients given the weekly controlled-release exenatide showed a reduction in HbA_{1c} of 1.9 per cent compared with 1.5 per cent in those taking the twice-daily treatment. Also more of the weekly-treated arm achieved target HbA_{1c} levels of 7.0 per cent or lower.
http://tinyurl.com/59c4pa

• Diabetes patients who self-monitor their glucose four times a week are no more likely to hit HbA_{1c} targets than those who monitor once a week, a study published by PLoS suggests.
http://tinyurl.com/6j4z8a

SMC OKs micafungin for use in Scotland

Scottish Medicines Consortium officials have approved micafungin (Mycamine) for treating invasive candidiasis, and three cancer treatments for use in Scotland.

The organisation said that micafungin offered an additional treatment option at a reasonable price, and was also indicated for use in children.

The approved cancer treatments include rituximab (MabThera) for use in previously untreated patients with follicular lymphoma that has spread in combination with chemotherapy, alamtuzumab (MabCampath) for restricted use in leukaemia and permetrexed (Alimta) in patients with non-small cell lung cancer.

However, the organisation did not recommend icatibant (Firazyr) for treating acute attacks of hereditary angioedema and aripiprazole (Abilify) for prevention and treatment of moderate to severe manic episodes.
www.scottishmedicines.org.uk

Clinical News

Meta-analyses 'biased'

Meta-analysis results are being undermined by learned journal editors who prefer to publish trials with statistically significant results, say the authors of a review published by PLoS Clinical Trials. Failure to publish inconclusive trials may skew meta-analysis results, and journals should implement their protocols consistently.
http://tinyurl.com/66vdzn

Pain in Parkinson's

Pain may be more common in patients with Parkinson's disease, says a report in the September issue of Archives of Neurology. The pain in the study of 719 subjects was not associated with dystonia, and resembled cramping and arthritis.
http://archneur.ama-assn.org

Clinical Alerts – Sign up for C+D's clinical newsletter at www.chemistanddruggist.co.uk/register

MHRA Alerts and Announcements

Mixing drugs for use in palliative care Following consultations, the MHRA has announced it will not take action against nurse and pharmacist independent prescribers who prescribe mixtures of licensed medications for injection by syringe driver in palliative care, pending further advice from the Commission on Human Medicines. http://tinyurl.com/6exog5

Medicines Act 1968 Advisory Bodies Annual Report 2007 Now available from the MHRA. http://tinyurl.com/6obp4r

New Products

Salofalk 1.5g granules (mesalazine) For the treatment of acute episodes and the maintenance of remission of ulcerative colitis. Dr Falk Pharma, 01628 536616.

Diafalk 1500mg tablets (sodium phosphate monobasic monohydrate and disodium phosphate anhydrous) Indicated for preparing the bowel for certain diagnostic procedures. Dr Falk Pharma, 01628 536616.

SPC Changes

Exjade (deferasirox) Added information on use with anticoagulants and treatments that may cause stomach ulcer, and a warning on impaired hepatic function. Novartis Pharmaceuticals UK, 01276 698370, medicalinfo.phgbfr@novartis.com

Vectibix (panitumumab) Vascular disorder pulmonary embolism has been added as a common side effect. Amgen, 01223 436441, infoline@uk.amgen.com

Sutent 12.5mg, 25mg and 50mg hard capsules (sunitinib) Revised warnings and precautions. Pfizer, 01304 616161.

Crixivan 200mg and 400mg hard capsules (indinavir) Ritonavir should not be given with indinavir to patients with decompensated liver disease as ritonavir is principally metabolised and eliminated by the liver. Merck Sharp & Dohme, 01992 467272.

Teoptic 1 per cent and 2 per cent eye drops (carteolol) Patient should keep eyes closed for five minutes to minimise systemic effects and maximise local effects. Novartis Pharmaceuticals, 01276 698370, medicalinfo.phgbfr@novartis.com

Neoral Soft Gelatin Capsules, Neoral Oral Solution (ciclosporin) Treatment regimens containing multiple immunosuppressants (including ciclosporin) should be used with caution as their use may lead to lymphoproliferative disorders and solid organ tumours. Novartis Pharmaceuticals, 01276 698370, medicalinfo.phgbfr@novartis.com

DuoTrav eye drops solution (timolol maleate, travoprost) Travoprost has harmful effects on foetuses and newborn children, also added undesirable effects reported post-marketing. Alcon Laboratories, 01442 341234.

Lucentis 10mg/ml solution for injection (ranibizumab) Revised instructions on use. Novartis Pharmaceuticals, 01276 698370, medicalinfo.phgbfr@novartis.com

Fluvoxamine 50mg & 100mg film-coated tablets (fluvoxamine maleate) New information on suicidality. Wockhardt, 01978 661261.

Valtrex tablets 500mg (valaciclovir) Updated dosage in renal impairment. GlaxoSmithKline, 0800 221441, customercontactuk@gsk.com

Ceftriaxone 2g powder for solution for injection/infusion (ceftriaxone) Contraindications added. Wockhardt, 01978 661261.

http://emc.medicines.org.uk

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MUR ZONE

More than 100 MUR tips and guides are now online at: www.chemistanddruggist.co.uk/murzone

Products in brief

Forceval Jr out of stock

Forceval Junior multivitamin and mineral capsules (30s and 60s) are currently unavailable due to a manufacturing delay, reports Alliance Pharmaceuticals. The company says it is working with its supplier to resolve the disruption.
Alliance Pharmaceuticals
Tel: 01249 466966

Lemsip's liquid launch

Lemsip Max All in One liquid is newly available from Reckitt Benckiser. Said to treat all major cold and flu symptoms, the GSL product contains paracetamol, phenylephrine HCl, guaifenesin and cetylpyridinium chloride.
Price: £5.99/160ml
Pip code: 339-7023
Reckitt Benckiser
Tel: 01482 326151

Dexeryl orders

Orders for the new dry skin topical emollient Dexeryl (C+D, August 30, p22) should be placed with Mawdsley-Brooks, tel: 01908 525191, says manufacturer Pierre Fabre Dermo Cosmetique.

Beechams beefs up its All-in-One offering

Multi-symptom cold and flu treatment Beechams All-in-One is newly available in larger pharmacy-only packs. The liquid format is presented in a 240ml size, up from the 160ml GSL pack, while the tablets now come in 24s.

The launch is expected to drive sales through pharmacy and build on the latest unit growth of 12.5 per cent (source: AC Nielsen unit change MAT to w/e June 14, 2008), reports manufacturer GSK.

Supporting the Beechams brand this year is a £5 million promotional budget spanning TV, outdoor and press advertising. Activity will see the return of 'Brian' in television advertising in the 'Fight back with Beechams' campaign in which the All-in-One products will enjoy the main focus.

Prices and Pip codes: liquid £5.29, 330-9051; tablets £4.49, 330-9044
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Alvita monitors on price promo

Coinciding with this week's 'Know your numbers' blood pressure awareness event, UniChem customers can take advantage of a special offer on Alvita upper arm blood pressure monitors this month. The monitors, with a promotional RRP of £9.99, are designed for patients to use at home.

Alvita monitors are said to be easy to use, high quality, reliable devices, offering improved value for money for pharmacists and their customers.

Marina Wong, Alvita brand manager, comments: "Patients are becoming increasingly aware of health risks. This has been a big driver for the diagnostics market and in particular for affordable home diagnostic kits, which give the patient empowerment to manage their condition in the comfort of their own home."

More information is available from UniChem account managers.

Product info:
UniChem
Tel: 020 8391 2323

Wisdom minds the gaps

Oralcare brand Wisdom has extended its interdental cleaning options with the launch of two products.

Clean Between interdental brushes feature soft rubber filaments and are wire-free for gentle cleaning. They are said to be ideal for implants.

The second newcomer is a 0.7mm brush in the interdental brush range. With a long tapered handle for optimum cleaning control, the product is coloured yellow to distinguish it from the 0.45mm (orange) and 0.6mm (blue) variants.

Prices and pip codes:
Clean between £2.99/20, 340-4928; 0.7mm brush £1.99/5, 340-4910
Ceuta Healthcare
Tel: 01202 780558

Sudafed prepares for winter woes

Decongestant brand Sudafed has added two new GSL lines ahead of the winter season.

Non-drowsy Sudafed congestion and headache (paracetamol, caffeine and phenylephrine capsules) provides relief from a blocked nose while treating headache symptoms alongside. Sudafed day and night (paracetamol, caffeine (day only) and phenylephrine capsules) provides users with two different capsules for daytime and night-time use.

Supporting the brand is a £4 million advertising campaign throughout the winter, described by manufacturer McNeil as adding "a touch of humour" while positioning Sudafed as the expert for all congestion-related symptoms.

Television advertising will be key and POS materials, including showcards and window posters, are available.

Price: £3.99/16
McNeil Products Ltd
Tel: 01628 822222

Grandma is BOGOF

Grandma Vine's antiseptic gel is the subject of a buy one get one free banded pack promotion this month. Containing only natural ingredients, the product is said to help keep moisture within the skin. Organic cider vinegar provides antibacterial activity. Once applied, the gel dries to form a protective seal to prevent infections while keeping moisture in.

Product info:
Lifeplan Products
Tel: 01455 556281

Organic route to a close shave

Organic Shave Oil is newly available from Absolute Aromas.

Combining aromatic essential oils and carrier oils, the product is designed to give a clean, close shave, leaving the skin soft, smooth and fresh, says the company. The oil leaves no greasy residue, does not clog the pores and is suitable for sensitive skin.

Peppermint oil gives a cooling sensation while lavender promotes skin growth and patchouli tones the skin, reducing redness and helping the complexion look youthful.

Carrier oils include apricot kernel, jojoba, calendula and sunflower oils, all of which are highly moisturising. Cedarwood oil gives the product a masculine aroma.

Each 15ml bottle is sufficient for 100 shaves.

FREE!
We have five packs of six Organic Shave Oils to give away to C+D readers. Email your details by September 21 to competitions@cmpmedica.com with 'Shave oil' as the subject

Prices and Pip codes:
£4.50/15ml; 340-4621
Absolute Aromas
Tel: 01420 540400

Numb needle fear

Dermal anaesthetic cream Emla has launched a pharmacy campaign to highlight the product's potential use for needle-phobics.

The promotion will feature in-store leaflets and posters, a website and a pre-injection numbing kit including occlusive dressings as well as the cream.

Community pharmacist Graham Phillips said: "I believe topical dermal anaesthetics, with their multitude of uses, should be a staple in every household so long as we make patients aware of the 'dos' and the 'don'ts'."

Product information:
AstraZeneca
Tel: 01582 836000
www.emla.co.uk

Products advertised on TV next week

ClearZal: All areas except GMTV

First Response Early Results Pregnancy Test: All areas

Frontline Spot On: GMTV, five, Sat, West Country

Hedrin: GMTV, five, Sat

Sensodyne: All areas

PharmaSite for next week: Nytol – windows, **Nytol** – in-store, **Nytol** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

The saga of the government's incontinence and stoma appliance consultation continues. **Emma Wilkinson** discusses the latest developments

Deal or no deal?

For those of you who have been following the twists and turns of the government's consultation on the provision of stoma and incontinence appliances, it may seem like a conclusion will never be reached.

We are now on the fifth consultation document over part IX of the Drug Tariff (although the section on dressings and chemical reagents has now been agreed) and health ministers say they are confident the end is in sight.

The past four years of wrangling have caused a fair deal of frustration on all sides. So what is it all about?

Background

The current arrangements for provision of stoma and incontinence appliances have been in place for 20 years without review and it is generally accepted there is a real need for overhaul.

And it is not a simple task. There are more than 5,000 items under Part IX of the Drug Tariff with no transparency

C+D & TENA

TUTORIAL 44

The four ages of incontinence

AIM

To improve the services offered to clients suffering from incontinence

OBJECTIVES

- To know which groups of people are at most risk of suffering incontinence
- To understand the differing causes of incontinence
- To know how incontinence can be managed in different 'at risk' groups
- To know which incontinence products are appropriate for different 'at risk' groups

Urinary incontinence affects three to six million people in the UK, however there are certain times of life when the likelihood of suffering is increased. Management can be simple and pharmacists are well placed to provide advice and guidance

Accredited by THE COLLEGE OF PHARMACY PRACTICE

C1f, C2a, C2f

Urinary incontinence affects three to six million people in the UK, with varying degrees of severity.[1] While it is often dismissed as being a minor, inconvenient problem, it is, says a Cochrane review, a serious medical condition as it can lead to urinary tract infections, pressure ulcers and perineal dermatoses.[2] It also has a significant effect on sufferers' quality of life.[2]

Pharmacists are in a frontline position to identify individuals who are self-treating urinary incontinence, as less than half of adults with moderate to severe urinary incontinence seek advice from a healthcare professional.[3]

Defining incontinence

Put simply, urinary incontinence is 'any involuntary leakage of urine'.[2] There are several different forms of incontinence:

stress – the most common type, where urine leaks out when the bladder experiences a sudden increase in pressure during physical activities, such as coughing, sneezing, laughing, lifting or heavy exercise.[1] The amount of urine passed is usually small.

urge – the second most common type (and also known as overactive bladder) causes a sudden, intense need to pass large volumes of urine, often with only a few seconds warning.[1] Frequency of urination may be increased and may also occur at night. Stress and urge incontinence together account for most incontinence.[1]

overflow – sufferers frequently pass small trickles of urine and suffer incomplete bladder voiding.

mixed – some individuals suffer from both urge and stress incontinence.

Pregnancy

Prevalence and causes

Women are twice as likely to experience urinary incontinence as men,[1] with pregnancy and childbirth particular risk factors.[3] This results in stress incontinence.[1]

In pregnancy, this is due to mechanical pressure of the expanding foetus on the pelvic floor muscles,[3] resulting in incompetent urethral sphincter that allows urine leakage when bladder pressure is raised. The prevalence of incontinence increases during pregnancy and the immediate weeks following childbirth.[3]

Prognosis

Although most women find their incontinence resolves within six weeks of giving birth, a Scottish study revealed 29% of women still had problems three months post-partum.[4]

Management

Pelvic floor muscle training (PFMT) is the first choice for managing stress incontinence.[3,6] PFMT in stress incontinence fulfils a dual approach: to improve pelvic floor muscle strength and long-term structural support for the pelvis and to train women to pre-contract the pelvic floor muscle during periods when bladder pressure increases, e.g. during coughing, thus preventing leakage.[2]

NICE guidelines recommend PFMT should be offered to all women during their first pregnancy to prevent incontinence problems.[6] Treatment should comprise at least eight contractions, three times daily for a minimum of three months.[6] Electrical stimulation and biofeedback can be considered for women who cannot actively contact their pelvic floor muscles.[6] The drug duloxetine is used as an alternative to surgical treatment.[6]

For women who are developing pelvic floor strength, in the interim period, disposable continence pads can be used to absorb light to moderate leakage (see box). Pharmacists may find women use sanitary products, however, these absorb only 10% of urine leakage, resulting in potential leaks.

Menopause

Prevalence and causes

The menopause is another critical period for women with respect to urinary incontinence as the drop in oestrogen results in a weakening of the muscles controlling the bladder and sphincter tone.[1] This leads to stress incontinence.

The menopause is a likely reason for the early 50s being the peak time for incontinence in women.[5] However, it is not the only factor. A US study of middle-aged women found the prevalence of urinary incontinence is higher in those with children, Caucasian women and increased with higher body mass index.[5]

Continence products

Disposable products come as three types:[12]

- Pads without waterproof backing – to be inserted into continence pants and allows pad to be changed without removing pants. Good for light to moderate incontinence, e.g. stress incontinence
- Shaped pads with a waterproof backing – smaller ones, suitable for light incontinence (e.g. stress or overflow) can be worn inside normal underwear; for men absorbent pouches are available. Larger pads for moderate to heavier incontinence (e.g. urge) should be worn under continence pants.
- All-in-one style – these are for heavy incontinence or for night time use.

Customers may need different types of pads at different times, e.g. if urge incontinence is the problem, then a lighter pad during the day, but a more absorbent pad at night.

Washable products can be more comfortable, but they are slow to dry and are less absorbent than a disposable pad of similar size.

Management
As with stress incontinence related to pregnancy and post-childbirth, PMFT is also the foundation of treatment in menopausal women. In addition, boosting oestrogen levels with hormone replacement therapy can help retain pelvic floor muscle strength for some women.[1]

Prostate

Prevalence and causes
The prevalence of incontinence in men of all ages is lower than that of women.[7] There is one exception, overflow incontinence, which is rare in women.[1] This is most common in men with a slightly enlarged prostate gland (benign prostatic hyperplasia, or BPH) which is present in around 60% of men by the age of 60 years, and in 90% of men by the age of 85.[7] This enlarged prostate presses on the urethra, making it difficult for the bladder to void and fill up completely, leading to urge incontinence.

Management
Drug treatment is recommended for those with moderate to severe lower urinary tract symptoms associated with benign prostatic hyperplasia.[7] If urinary tract symptoms, such as incontinence, are bothersome and there is prostate obstruction but no risk factors for BPH progression, an alpha-blocker (alfuzosin, doxazosin, prazosin, tamsulosin or terazosin) is recommended, with symptoms improving within several days.[7] If the symptoms are not bothersome, but there are risk factors for progression of BPH, then a 5-alpa reductase inhibitor should be given as this will help reduce prostate size.[7]

Surgery for BPH is reserved for men who have failed to respond to drug treatment or who are at risk of complications.

For men who wish to use pads while they adjust to medication or consider surgery, there is a range of options, see box.

Reflection

Having read this article reflect on the following aspects of your current practice:

1. Is your pharmacy offering best advice in this sensitive area?
2. How can the service be improved?
3. Are your staff knowledge and training. adequate?

Action

To help you in the reflection process carry out the following actions

1. Find out how primary care incontinence services operate in your area.
2. Audit sales of disposable incontinence products from your pharmacy. Who is buying which products? Is your product range appropriate?

Elderly

Prevalence and causes
During the ageing process, the pelvic floor muscles become weakened, leading to an increased risk of incontinence.[1] Urge incontinence is a particular problem, with almost a third of those over 75 years affected.[9] Although it is thought that urge incontinence is the result of incorrect signals between the brain and the bladder, the causes are often difficult to determine[1] Lower urinary tract infections, certain nervous system disorders (e.g. Parkinson's disease, stroke) and, in men, an enlarged prostate are implicated in some cases.[1]

Management
First line treatment for urge incontinence is bladder training for at least six weeks.[6] This aims to gradually stretch the bladder so it can hold larger volumes of urine and allow sufferers to return to a normal pattern of bladder emptying, with no more than six to eight bladder voidings per day.[10]

If frequency remains a problem or bladder training is ineffective, then an anti-muscarinic drug should be recommended as these reduce involuntary detrusor muscle contraction. Oxybutinin is the first line choice[6] as it also has a direct effect on urinary smooth muscle.[11] Alternatives to oxybutinin should not be offered unless there is intolerance, in which case darifenacin, solifenacin, tolterodine or trospium can be used.[6] In rare cases, surgery is an option.[10]

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If you pass this module, and want the appropriate certificate for this College of Pharmacy Practice accredited tutorial, complete the form below and send the original (or a photocopy) to: Pharmacy Projects, CMPMedica Ltd, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE before October 25, 2008. Please enter your name, pharmacy, address, and phone number below:

Name:

Address:

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1. Overflow incontinence is rarer in women than men

❑ True ❑ False

2. Washable continence pads are generally more absorbent than disposable pads of a similar size

❑ True ❑ False

3. First line treatment for urge incontinence is bladder training for at least four weeks

❑ True ❑ False

4. During pregnancy and childbirth women are at particular risk of urge incontinence

❑ True ❑ False

5. People with overflow incontinence suffer from incomplete bladder voiding

❑ True ❑ False

6. Incontinence sufferers may need a light pad during the day, but a more absorbent pad at night

❑ True ❑ False

7. PFMT for women in their first pregnancy should comprise at least eight contractions, twice times daily for a minimum of three months

❑ True ❑ False

8. Anti-muscarinic drugs reduce involuntary detrusor muscle contraction

❑ True ❑ False

9. The early 60s is a peak time for incontinence in women

❑ True ❑ False

10. Urge incontinence affects nearly half of those aged over 75 years of age

❑ True ❑ False

> Pharmacy representatives warned that the proposals, as they stood at the end of 2007, would reduce patient access by increasing the number of times pharmacists end up supplying an appliance at a loss

around reimbursement fees and payment for providing the service in the first place.

In fact, many additional services such as home delivery come as part and parcel of current schemes, but there is no actual requirement to provide them, leaving patients at the mercy of local arrangements.

There is currently a big variation in the availability of home delivery, advice and support lines around the country. In short, the government wants to make the process clearer so it knows exactly where the £260 million of NHS money spent on this every year is going and ensure consistency of provision around the country – something it says is not happening currently. Moreover, it believes it is not benefiting from apparent reductions in manufacturing costs and wants to cut millions from the current bill.

From the pharmacists' point of view, the current arrangements often leave them dispensing at a loss, and having to offset costs with other NHS work. Or they are forced not to dispense the items at all. Another bugbear is pharmacists and appliance contractors are reimbursed under different arrangements, leading to discrepancies in payments.

In the previous, and supposedly final consultation, which completed in December 2007, the Department and pharmacists had definitely not reached common ground on these issues.

Sticking points

There were 140 responses to the last consultation and the failure to reach an agreement boils down to a few simple points on ensuring patient access and continuity of service and affordability. Pharmacy representatives warned that the proposals, as they stood at the end of 2007, would reduce patient access by increasing the number of times pharmacists end up supplying an appliance at a loss.

Negotiators also raised concerns that the proposals would lead to a lack of competition in a market that is supplying a very vulnerable group of patients.

And despite several changes to payment infrastructure and fees, there was also almost universal criticism about the Department's costing information.

In a statement PSNC said: "The costing information provided by the Department to date is wholly unrealistic and fails to offer any incentive to contractors to provide the service." Representatives from industry argued that any new arrangements had to be more affordable.

What's new?

The Department took this on board and earlier this year held a series of meetings with the various stakeholders who had responded to the September consultation. It led to the latest proposals that the Department believes meet the target of broadly maintaining the current level of remuneration for appliance contractors while extending pharmacists' fees for some services. Stakeholders had until September 8 to respond to the revisions.

Under the proposals, every pharmacist (and appliance contractor) in England will be expected to provide as

Product news

Dry nights with Tena

A Maxi Night variant has been added to the Tena Lady incontinence range. Designed for women aged 45+, the product claims to be the UK's only bladder weakness product specifically for night-time use.

Supporting the launch, TV advertising is scheduled to run from October through to the end of the year backed up by PR, press and online activity. Samples are being distributed with money-off next purchase coupons.

An estimated 50 per cent of women with bladder weakness use towels at night but some worry products will not be effective enough while others use two towels at a time. Used to buying night-time towels for periods, Tena hopes the new Maxi Night variant will establish a new segment within the bladder weakness market. Maxi Night is priced at £2.99 for six; Pip code 338-5952.

SCA Hygiene; tel: 01582 6774001

standard a dispensing service, home delivery for catheters, laryngectomy and tracheostomy (not included in the previous list) prescription items and some other listed items if requested by the user, complementary supplies of wipes and disposal bags where necessary and provide elastic hosiery and trusses that require fitting or measuring.

As an advanced service, pharmacists can also choose to provide customisation of stoma appliances and appliance use reviews. But the issue is not really around what service is provided but what level of remuneration is available.

In the latest revisions, the dispensing fee remains 90p per prescription item as there was no objection to this, but the additional dispensing fee for home delivery and complimentary supplies of wipes and disposal bags has been increased from £3.23 to £3.40 per item.

This move was in response to criticism that the previous calculations on the costs of disposal bags and wipes were unrealistic and that the fee needed to include the costs of a next-day delivery service.

Both pharmacists and appliance contractors will now be paid £1.28 for elastic hosiery measurement and £1.97 for trusses.

Stoma customisation is now worth £4.23 per item compared to £3 and the cap of 25,000 items prescribed per month has been removed, after stakeholders warned such a threshold could disrupt services.

There has been a lot of debate about how much it costs to provide specialist nurse visits. But for those pharmacies wishing to take on the extra tasks of appliance use reviews, the Department proposes £54 for home visits and £27 for reviews done on the premises, compared to a previous flat rate of £40. And the cap of one review for every 70 items dispensed has now been lowered to 35.

In addition, reimbursement levels part IXA (catheter), IXB and IXC should be reduced by 2 per cent, the Department says, which would reduce the costs to primary care by £5.2m a year (although some manufacturers will be exempt from this).

Most respondents had called for a mechanism for reviewing the fee on an annual basis to be built in and this has now been added.

Is an agreement likely?

Health minister Dawn Primarolo said in June, after the publication of the revised proposals, that she is confident the latest recommendations will maintain the remuneration currently received by appliance contractors while extending pharmacists' fees. She said she "fully admitted" she had been frustrated that the earlier consultations had not brought the issue to a conclusion.

The Department has estimated that under the latest offer, the total annual reimbursement would be £185m for stoma appliances and related services and £112m for urology appliances.

The consultation closed on September 8 and it remains to be seen whether pharmacists and manufacturers are eventually in agreement with the government.

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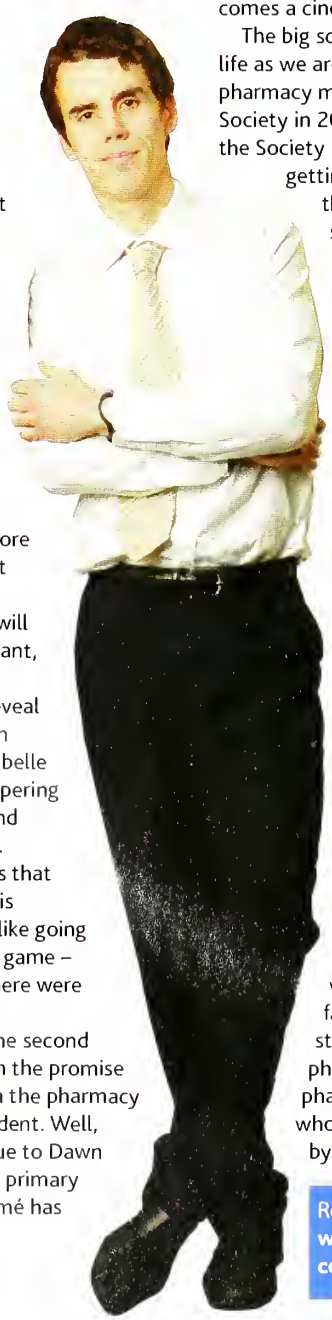
British Pharmaceutical Conference blog

Have you heard the one about the tsar, the president and the page 3 model?

C+D news editor Max Gosney shares his views on the RPSGB's flagship event



Day one: BPC is in a dilemma. The show has faced stiffening competition from rival events such as the Pharmacy Show, and its patron, the RPSGB, has hit rocky times with the impending removal of its regulatory role. But perhaps BPC's biggest issue has been a failure to lure more grassroots pharmacists.

The RPSGB claims to have found the remedy. This year, doors opened on a Sunday for the first time, to try and attract more everyday pharmacists. Cut price tickets have been introduced and seminars will aim to provide more relevant, hands-on advice.

The coming days will reveal whether the makeover can once again make BPC the belle of the ball, or is simply papering over the cracks in the grand dame of pharmacy shows.

My overall impression is that BPC is quiet. Attending this afternoon's seminars felt like going to watch a Millwall home game – everywhere you looked there were empty seats.

Day two: Crunch time. The second day dawns, brimming with the promise of headline speeches from the pharmacy minister and RPSGB president. Well, that was the script but, due to Dawn Primarolo pulling out, DH primary care tsar David Colin-Thomé has been drafted in as a late substitute for the elusive pharmacy minister.

Up next is Steve Churton, making his inaugural BPC president's speech. But first comes a cinematic interlude.

The big screen behind the stage kicks into life as we are screened a highlights reel of pharmacy media coverage secured by the Society in 2008. Now, credit where it's due, the Society has upped its game in terms of getting pharmacy-linked stories into the national press and its spokespeople onto TV and radio shows.

All publicity is good publicity as they say and if Melinda Messenger and Judith Chalmers can help raise awareness of how pharmacists can help with hayfever treatment and holiday health advice, then all well and good. But let's not forget that there are plenty of challenges within the sector and I'm sure pharmacists would value a strong representative voice championing their corner whether it be on the devastation of category M cuts or the stories of pharmacists stressed by spiralling workloads.

I didn't see any signs that the show had appealed beyond its traditional audience by opening on Sunday this year. If I'd closed my eyes it could have been my first BPC in 2005 (bar BPC TV and a few other worthy initiatives). It's a firm favourite with academics, RPSGB staff, suppliers and some pharmacists. But the community pharmacist audience – you guys who read C+D – were conspicuous by your absence.

Read more at **www.chemistanddruggist.co.uk/bpcblog**

Delegates get WiiFit

British Pharmaceutical Conference delegates took time out from speeches, presentations and discussion panels to play on the Co-operative Pharmacy stand's WiiFit.

The multiple's conference team brought along the fitness games console because, according to the stand spokesperson, "it ties in with healthy living and the way pharmacy's moving towards being a healthy living centre".

One RPSGB staff member's day was made when she was told her WiiFit age was five years younger than her birth date would suggest, and delegates were also seen getting to grips with football headers, slalom skiing and the hula, which the spokesperson described as "very amusing".

Participants were rewarded for their workouts with a chocolate giveaway.

Fabulous freebies

PostScript's favourite freebie accolade goes to the Pharmacists' Defence Association, which was giving away tablets to help delegates deal with stress. But the PDA stand representatives weren't having to whip out their independent prescriber pads – the 'stress pills' in question were of the palm-sized, foam variety, to be squeezed as a relaxation technique!

A load of balls?

BPC may be one of the more traditional pharmacy events, but PostScript was delighted to see that even the RPSGB cannot prepare for everything. During a session on the responsible pharmacist legislation, one audience member made their views known. PostScript distinctly heard a cry of "balls" from the back rows.

SKILLS FOR

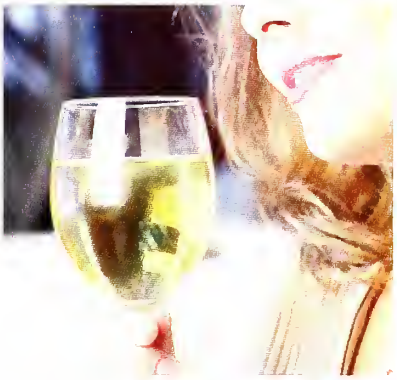
Public Health

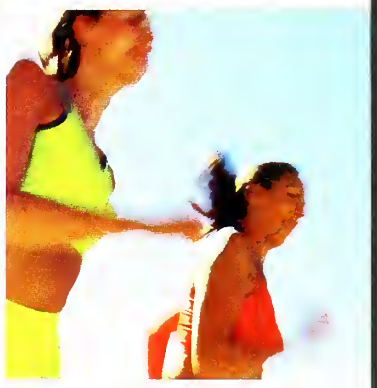
Module 1 with this issue

Public Health: The Big Issue

This course provides a timely opportunity for pharmacists to update their public health knowledge and skills in preparation for the development of new contractual services.

Alastair Buxton
Head of NHS Services, PSNC





Skills for Public Health is:

- A modular distance learning course for community pharmacists.
- Delivered monthly through C+D magazine and on *www.chemistanddruggist.co.uk* from September 2008.
- Written by public health experts and practising pharmacists.
- Part of the Medway Short Course Pathway. On completion students will receive a Practice Certificate and five credits towards a postgraduate qualification.

The course is designed to assist pharmacists achieve public health competences which have been drawn up in conjunction with PSNC. These competences underpin any public health-related service that pharmacists may wish to deliver at local level as part of an Advanced or Enhanced Service through the pharmacy contract.

From C+D in association with Medway School of Pharmacy and PSNC, supported by an educational grant from GlaxoSmithKline.

THE COURSE WILL COVER:

- **Public Health in the UK – an overview**
- **Evidence base for interventions such as diet and nutrition, smoking cessation, alcohol and drug misuse programmes and exercise**
- **Behaviour change: Theory into Practice**
- **The Pharmacist as Public Health Practitioner**
- **Practical advice on running community pharmacy-based services to address:**
  - **Addictions (smoking cessation, alcohol and drug misuse)**
  - **Obesity**
  - **Cardiovascular disease (vascular risk assessment)**

For more information contact Pauline Sanderson, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent, TN9 1SE. Tel: **01732 377269** Email: **psanderson@cmpmedica.com**

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Precautions and warning: Lemsip Max All in One Liquid is not suitable for long term use. Paracetamol should be used with care for patients with severe renal or hepatic impairment. The hazard of overdose is greater than those with non-cirrhotic alcoholic liver disease. Do not take with any other cold or decongestant medicines or any other paracetamol containing products. Immediate medical advice should be sought in case of an overdose even if you feel well, because of the risk of delayed serious liver damage. Phenylephrine should be used with care in patients with hyperthyroidism, cardiovascular disease, diabetes mellitus, closed angel glaucoma, prostatic enlargement and hypertension.
Side effects: Adverse effects of paracetamol are rare, but hypersensitivity including skin rash may occur. There have been reports of blood dyscrasias including thrombocytopenia and agranulocytosis, but these were not necessarily causally related to paracetamol. Phenylephrine hydrochloride: High blood pressure with headache, vomiting and rarely, palpitations. Also, rare reports of allergic reactions. Guaifenesin has occasionally been reported to cause gastro-intestinal discomfort, nausea and vomiting, particularly in very high doses.
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Holder of Marketing: Galpharm Healthcare Ltd, South Yorkshire, S75 3SP Date of preparation: September 2008 Lemsip, Lemsip Max and the sword and circle are trade marks.

Information about adverse event reporting can be found at www.yellowcard.gov.uk
Adverse events should also be reported to Medical Services, Reckitt Benckiser Healthcare (UK) Ltd. Telephone 0500 455456.

*AC Nielsen unit sales 2007/08 season

C+D
Chemist+Druggist

Price service

This Supplement updates the latest Chemist & Druggist Monthly Price List. It provides a list of amendments for this week only. This supplement should not be discarded until receipt of the next monthly price list. Trade prices are per unit unless otherwise stated.
Italic figure *(0.14)* is the manufacturers recommended price. Light upright (0.14) is a suggested guide. **a** = price advanced. **r** = price reduced. ● = new entry. **d** = deleted. **c** = change or correction. **i** = insert. **Two simple rules for price checking. 1.** Look under 'This Week's changes'. If price is not listed. **2.** Refer to the last main price list. *Price is latest notified.*

This week's changes to the September Price List.

	PIP code	Trade	VAT	Retail	
A.VOGEL (BioForce)					
single herbal preparation					
devils claw tincture tablets	50 298-9515	7.09	S	*12.49*	d
Aesculus					
tablets	60 262-9285	5.15	S	*8.99*	d
Aesculus forte					
tablets 50mg	30 288-0219	5.15	S	*8.99*	d
ABSOLUTE AROMAS (Absolute Aromas)					
organic shave oil	OR200-15ml 340-4621	2.55	S	*3.83* GSL	a
CAPRILON (SHS)					
Effective September 8					
specialised formula food	420g 205-6547	14.28	Z	BS	a
DANSAC (Dansac)					
InVent Symmetrical Convex					
drainable					
pre-cut	10	25.46	S	DT	
opaque 343-25 25mm 262-7198, opaque 343-30 30mm 262-7206					a
opaque 343-35 35mm 262-7214					a
Nova					
ileostomy pouch					
cut-to-fit	10	38.68	S	DT	
opaque 841-24 15-24mm 309-3945, opaque 841-37 15-37mm 309-3952					a
opaque 841-46 15-46mm 309-3960					a
pre-cut	10	38.68	S	DT	
clear 882-25 25mm 309-3986, clear 882-30 30mm 309-3994					a
clear 882-35 35mm 309-4000, opaque 841-20 20mm 309-3838					a
opaque 841-25 25mm 309-3846, opaque 841-30 30mm 309-3853					a
opaque 841-35 35mm 309-3861					a
DIALAMINE (SHS)					
Effective September 8					
dietary supplement	200g 019-3920	110.64(4)	Z	BS	d
	400g 326-3845	230.12(4)	Z	BS	a
DR STUARTS (Simpkin, A L)					
candies	175g	11.10(6)	S	*2.89*	
apple & ginger 0214 341-3002, cherry & echinacea 0215 341-3010					•
lemon, manuka honey & chamomile 0216 341-3028					•
peppermint & eucalyptus 0217 341-3036					•
DUOBAR (SHS)					
Effective September 8					
high energy bars					
protein free	45g	12.31(8)	Z	BS	
natural 246-3479, strawberry 246-3487, toffee 280-8012					a
DUOCAL (SHS)					
Effective September 8					
Super Soluble					
dietary supplement	400g 031-4989	56.64(4)	Z	BS	a

	PIP code	Trade	VAT	Retail	
DUREX (SSL International)					
lubricant					
play o					
gel	10030144-15ml 341-3358	26.79(3)	S	*14.99*	•
EASIPHEN (SHS)					
Effective September 8					
dietary supplement	250ml	136.08(18)	Z	BS	
forest berries 306-6008, orange 322-5513, tropical 322-5505					a
ELASTOPLAST (Beiersdorf)					
Plasters					
shrek	16 325-6328	19.00(10)	S	*2.55*	d
ELEGANT TOUCH (Original Additions)					
NAILS					
false nails					
detail therapy	24	27.36(6)	S	*8.00*	
nautical 40 13 301 341-3382, grecian goddess 40 13 302 341-3390					•
wanderlust 40 13 303 341-3408, stardust 40 13 305 341-3416					•
golden moon 40 13 306 341-3424, show stopper 40 13 307 341-3432					•
militarian 40 13 308 341-3440, copper burst 40 13 309 341-3457					•
pink lady 40 13 310 341-3465, hippy tip 40 13 311 341-3473					•
black widow 40 13 312 341-3481, stargazer 40 13 313 341-3499					•
sundance 40 13 314 341-3507, checkers 40 13 315 341-3515					•
safari 40 13 316 341-3523, rainbow 40 13 317 341-3531					•
vintage 40 13 318 341-3549, tied up 40 13 319 341-3556					•
buckled up 40 13 320 341-3564, waverley 40 13 321 341-3572					•
indian ink 40 13 322 341-3580, butterfly 40 13 324 341-3598					•
storm 40 13 323 341-3606					•
EMSOGEN (SHS)					
Effective September 8					
dietary supplement	100g	57.60(10)	Z	BS	
flavoured 210-9668, unflavoured 210-9676					a
ENERGIVIT (SHS)					
Effective September 8					
specialised formula food	400g 280-3245	68.92(4)	Z	BS	a
FIRST RESPONSE (Church & Dwight)					
pregnancy testing kit					
one step	1 010-3283	29.28(6)	S	*6.75*	i
FISHER-PRICE (Vogue International)					
backpack changing bag	294-5020	16.50	S	*29.99*	d
bottle brush	309-3598	1.90	S	*3.49*	a
childs coverall bib	341-1691	3.85	E	*6.99*	•
feeding bottle	125ml/4oz 294-4650	1.90	S	*3.49*	a
	250ml/9oz 294-4635	2.20	S	*3.99*	a
feeding bottles	3 125ml 309-3614	4.40	S	*7.99*	d
	3 250ml 309-3606	4.99	S	*8.99*	d
teats	4 294-4718	1.80	S	*3.29*	d

		PIP code	Trade	VAT	Retail		
weaning bowl & spoon set		294-4783	2.20	S	*3.99*		a
weaning spoons	4	294-4809	1.65	S	*2.99*		a
electric steam steriliser							
& contents		309-3572	32.00	S	*54.95*		a
night soother							
child	2 6mnths +	341-1717	2.20	S	*3.99*		•
infant	2 0-6mnths	341-1741	2.20	S	*3.99*		•
silicone child soother							
with case, lead & clip	3+m	309-3580	2.75	S	*4.99*		a
silicone infant soothers	2		2.20	S	*3.99*		
0-6 months 294-4825, 6+ months 294-4858							a
storage containers							
baby food	3	341-1733	2.20	S	*3.99*		•
teats	2		1.90	S	*3.49*		
fast flow 294-4684, medium flow 294-4676, variable flow 294-4700							a
slow flow 294-4668							d
training handles							
for feeding bottles	2	294-4767	1.26	S	2.29		d
training mug							
flip spout		341-1725	1.90	S	*3.49*		•
non-spill		294-4874	1.90	S	*3.49*		a
vacuum flask							
food warming		341-1709	7.00	S	*12.99*		•
GALACTOMIN 17 (SHS)							
Effective September 8							
specialised formula food	400g	010-6229	13.16	Z			a
GENERAID (SHS)							
Effective September 8							
protein supplement	200g	028-2327	95.88(4)	Z	.	BS	a
GENERAID PLUS (SHS)							
Effective September 8							
protein supplement							
for children	400g	086-3506	102.90(6)	Z		BS	a
GRIPTIGHT (Creative Max Imports)							
Nearer to Nature							
soothers							
with clip		341-3275	13.41(6)	S	*3.99*		•
HCU-LV (SHS)							
Effective September 8							
powder	30 27.8g		386.17	Z			
tropical 322-5497, unflavoured 322-5430							a
HEPATAMINE (SHS)							
Effective September 8							
dietary supplement	50g	253-4253	32.53(4)	Z			a
HUBNER (Biotorce)							
Silicea cold sore lip gel	5g	323-4580	3.09	S	5.99		d
JUVELA (SHS)							
Effective September 8							
low protein							
bread rolls	5 70g	206-3485	23.22(6)	Z	.		a
mix	500g	035-2765	79.92(12)	Z		BS	a
pizza bases	2 180g	282-0538	29.48(4)	Z		BS	a
loaf	400g		18.72(6)	Z	..		
sliced 092-3961							a
unsliced 023-9608							d
low protein-gluten free							
cookies	125g		78.12(12)	Z	.		
cinnamon 053-2564, orange 053-2556, chocolate chip cookies 053-2572							a
JUVELA (Juvela)							
gluten-free							
fresh sliced loaf	400g		24.32(8)	Z	..		
white 322-0217							a
LIQUID DUOCAL (SHS)							
dietary supplement	250ml	023-2744	37.68(12)	Z	.	BS	a
LIQUIGEN (SHS)							
Effective September 8							
dietary supplement	250ml	003-9040	87.12(12)	Z		BS	a
LOCASOL (SHS)							
Effective September 8							
specialised formula food	400g	000-2535	109.74(6)	Z	..		a
LOPHLEX (SHS)							
Effective September 8							
dietary supplement							
sachets	30 27.8g		226.87	Z	.	DT	
berry 313-6769, orange 313-6777, unflavoured 313-6751							a
LOPHLEX LQ (SHS)							
Effective September 8							
r/t/d protein substitute	3 125ml		242.70(10)	S		DT	
berry 322-4639, citrus 322-0613, orange 322-0621							a
LOPROFIN (SHS)							
Effective September 8							
P K U drink	200ml	043-0827	16.20(27)	Z		BS	a
low protein products							
breakfast cereal	375g	266-0140	25.92(4)	Z		BS	a
egg replacer	2 250g	022-8031	12.14	Z	..	BS	a
egg white replacer	100g	270-1456	78.10(10)	Z		BS	a
mix	500g	004-6607	118.98(18)	Z	.	BS	a
part baked rolls	4 65g	266-0157	19.68(6)	Z	..	BS	a
rice	500g	232-3376	40.26(6)	Z	.	BS	a
sweet biscuits	150g	038-4487	24.96(12)	Z		BS	a
white rolls	4	228-3257	17.46(6)	Z	..	BS	a
biscuits							
cream filled chocolate	125g	042-7989	24.96(12)	Z	.	BS	a
cookies	100g		66.12(12)	Z	.	BS	
chocolate chip 055-9237, cinnamon 055-9278							a
crackers	150g		34.08(12)	Z	.	BS	
herb 277-4446, original 039-7125							a
cream wafers	100g		24.24(12)	Z		BS	
chocolate 091-7997, orange 052-9578, vanilla 038-4495							a
dessert mix	150g		22.92(6)	Z		BS	
chocolate 328-5129, strawberry 328-5137, vanilla 328-5145							a
flakes	375g		37.44(6)	Z		BS	
apple and honey 329-8429, chocolate 328-5160, strawberry 328-5152							a
loaf	400g		18.72(6)	Z	.	BS	
sliced 054-6150							a
pasta	500g		41.46(6)	Z	.	BS	
fusilli 331-5058, penne 331-5041, spaghetti 211-5251							a
pasta	250g		39.84(12)	Z	.	BS	
macaroni elbows 328-5194, piastoni 328-5202, tagliatelle 328-5210							a
pasta	500g		39.96(6)	Z		BS	
conchiglie 328-5178, gnocchetti sardi 328-5186							a
pasta							
animal shapes	500g	335-6169	39.84(6)	S		BS	c
lasagne	250g	298-1777	40.32(12)	Z		BS	c
vermicelli	250g	217-5966	41.28(12)	Z	.	BS	c
snack pot	47g		29.36(8)	Z	.	BS	
curry 291-2848, tomato & basil 312-8451							a
LORENZO'S OIL (SHS)							
Effective September 8							
special diet food	500ml	274-8721	65.45	Z			a
MAPLEFLEX (SHS)							
Effective September 8							
unflavoured	29g	313-1034	162.82(30)	Z		BS	a
MAXIJUL (SHS)							
Effective September 8							
liquid							
dietary supplement	200ml		38.40(30)	Z	.	BS	
neutral 051-7060, orange 052-6939							a

		PIP code	Trade	VAT	Retail		
Super Soluble							
dietary supplement	2.5kg	004-3547	35.88(2)	Z		BS	a
	25kg	019-5685	121.85	Z		BS	a
	200g	024-6827	8.16(4)	Z		BS	a
	4 132g	033-0548	20.20(4)	Z		BS	a
MAXISORB (SHS)							
Effective September 8							
dietary foods	5.30g		4.16	Z		BS	
chocolate 096-9006, strawberry 096-9022, vanilla 096-9030							a
MCT (SHS)							
Effective September 8							
oil	500ml	272-5125	11.50	E		BS	a
MEDIVEN ACTIVE (Medi UK)							
support hosiery							
Class II							
below knee			26.01	S	*36.67*		
marine DT340/3/II size II 334-0742							•
marine DT340/3/II size III 334-0759							•
marine DT340/3/IV size IV 334-0767, marine DT340/3/V size V 334-0775							•
marine DT340/3/VI size VI 334-0783, black DT340/5/II size II 334-0791							•
black DT340/5/II size III 334-0809, black DT340/5/IV size IV 334-0817							•
black DT340/5/V size V 334-0825, black DT340/5/VI size VI 334-0833							•
below knee petite			26.60	S	*37.51*		
black DT341/5/II size II 334-0841, black DT341/5/II size III 334-0858							•
black DT341/5/IV size IV 334-0866, black DT341/5/V size V 334-0874							•
black DT341/5/VI size VI 334-0882, marine DT341/3/II size II 334-0890							•
marine DT341/3/II size III 334-0916							•
marine DT341/3/IV size IV 334-0932, marine DT341/3/V size V 334-0940							•
marine DT341/3/VI size VI 334-0957							•
MINAPHLEX (SHS)							
Effective September 8							
special diet food	29g		98.92(30)	Z		BS	
chocolate 318-8695, flavoured 282-0199, unflavoured 282-0181							a
MINERS (Miners International)							
body lights							
shimmer cream			5.70(3)	S	*3.99*		
gold M18331 341-3663, bronze M18332 341-3671							•
eyeshadow							
eye shades			4.20(3)	S	*2.99*		
sky M18361 341-3762, golden eve M18362 341-3770, cloud M18363 341-3788							•
blush M18364 341-3796, california lilac M18365 341-3804							•
bronze M18366 341-3838, ice queen M18367 341-3846							•
forest M18368 341-3853							•
lace & body bronzer							
midas touch	M18301	341-3655	7.13(3)	S	*4.99*		•
lip gloss							
crystal crush			5.70(3)	S	*3.99*		
tropical M13505 341-3689, studio 54 M13504 341-3697							•
mango crush M13503 341-3705, heartbreaker M13502 341-3713							•
diamond dust M13501 341-3721, cocoa shimmer M13506 341-3739							•
nail colour			3.57(3)	S	*2.49*		
black velvet M18005 341-3614, blue monday M18006 341-3622							•
millenium gold M18011 341-3630, graphite M18036 341-3648							•
dancing in the moonlight M18029 341-3861							•
MODJUL (SHS)							
Effective September 8							
Flavour System							
dietary foods	100g		9.54	Z		BS	
blackcurrant 096-9113, pineapple 096-9360, orange 096-9386							a
harvest fruits 265-9076							d
dietary foods	20.5g		9.54	Z		BS	
grapefruit 265-9043, lemon/lime 265-9068, cherry vanilla 265-9050							a
MSUD AID III (SHS)							
Effective September 8							
dietary supplement	500g	259-2079	291.52(2)	Z		BS	a
MSUD ANALOG (SHS)							
Effective September 8							
special diet food	400g	023-7024	56.44(2)	Z	.	BS	a
MSUD MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	024-7064	153.88(2)	Z	.	BS	a
MSUD MAXAMUM (SHS)							
Effective September 8							
special diet food	500g		246.68(2)	Z		BS	
flavoured 228-6722, unflavoured 211-9204							a
NIASPAN (Abbott Nutrition)							
(nicotinic acid)							
tablets	500mg	56	299-6676	17.25	S	POM	c
	750mg	56	299-6684	26.25	S	POM	c
	1000mg	56	299-6692	34.75	S	POM	c
tablets, starter pack		21	299-6668	14.00	S	POM	c
NIVEA (Beiersdorf)							
lipcare							
light kiss	10ml	341-2277	111.36(48)	S	*2.99*		•
OAKMED OPTION (Oakmed)							
ileostomy microskin							
opaque							
M-41 series		30	81.03	S	..	DT	
cut to fit M-4155K 55mm 304-8881, cut to fit M-4160K 60mm 304-8907							d
ileostomy microskin pouch							
standard opaque							
MV-41 series		30	84.47	S	..	DT	
cut to fit MV-4155K 55mm 315-8656, cut to fit MV-4160K 60mm 315-8672							d
OPPO (Trans-Global Sports)							
compression stockings							
20mm			5.00	S	*9.99*		
beige 2820 small 341-5072, beige 2820 medium 341-5080							•
beige 2820 large 341-5098, beige 2820 ex large 341-5106							•
black 2820 small 341-5114, black 2820 medium 341-5122							•
black 2820 large 341-5130, black 2820 ex large 341-5148							•
25mm			6.00	S	*11.99*		
beige 2821 small 341-5155, beige 2821 medium 341-5163							•
beige 2821 large 341-5171, beige 2821 ex large 341-5189							•
black 2821 small 341-5197, black 2821 medium 341-5205							•
black 2821 large 341-5213, black 2821 ex large 341-5221							•
foot care							
arch pads		5459 341-5296	3.50	S	*6.99*		•
gel matatarsal bandage		6780 341-5460	4.50	S	*8.99*		•
metatarsal pads		5455 341-5270	2.75	S	*5.50*		•
		5456 341-5288	2.95	S	*5.95*		•
arch care			3.50	S	*6.99*		
pads 6750 small 341-5437, pads 6750 medium 341-5445							•
pads 6750 large 341-5452							•
bunion sleeve			3.50	S	*6.99*		
gel 6741 small 341-5403, gel 6741 medium 341-5411							•
gel 6741 large 341-5429							•
corn pad							
oval		6474 341-5361	4.50	S	*8.99*		•
heel pads			5.50	S	*10.99*		
with removable pads 5460 small 341-5304							•
with removable pads 5460 medium 341-5312							•
with removable pads 5460 large 341-5320							•
toe cap			3.00	S	*5.99*		
gel 6704 small 341-5379, gel 6704 medium 341-5387							•
gel 6704 large 341-5395							•
toe supports			1.99	S	*3.99*		
toe thong 6421 small 341-5338, toe thong 6421 medium 341-5346							•
toe thong 6421 large 341-5353							•

		PIP code	Trade	VAT	Retail		
maternity			4.50	S	*8.99*		•
belt 2262 ex small 341-4992, belt 2262 small 341-5007							•
belt 2262 medium 341-5015, belt 2262 large 341-5023							•
belt 2262 ex large 341-5056							•
medical supports							
arm sling			2.50	S	*4.99*		
mesh 3289 small 341-5239, mesh 3289 medium 341-5247							•
mesh 3289 large 341-5254, mesh 3289 ex large 341-5262							•
elastic abdominal binder			7.95	S	*14.99*		
ex ex large 2162 341-4976							•
elbow support			10.00	S	*19.95*		
hinged 1187 small 341-4901, hinged 1187 medium 341-4919							•
hinged 1187 large 341-4935, hinged 1187 ex large 341-4943							•
knee stabilizer			13.95	S	*26.99*		
ex ex large 1030 341-4877							•
knee stabilizer							
hinged			14.95	S	*28.99*		
ex ex large 1031 341-4885							•
knee supports							
closed	1023-one size	341-4869	5.50	S	*11.99*		•
closed			4.99	S	*9.99*		
ex ex large 1022 341-4851							•
open			6.50	S	*12.99*		
ex ex large 1021 341-4844							•
patella stabilizer			15.95	S	*29.99*		
ex ex large 1033 341-4893							•
OPSIL (Technovent)							
artificial eye lubricant							
standard	15ml	341-3754	5.10	S	*9.99* DT		•
thick	15ml	341-3747	5.10	S	*9.99* DT		•
P.K AID 4 (SHS)							
Effective September 8							
special diet food	500g	240-3988	112.04	Z			a
PANDA (Cedar Health)							
licorice bars	4 128g	341-1683	14.47(18)	S	*1.89*		•
PATIENTPAK (Patientpak)							
personal antimicrobial kit	PPAK1	341 3366	53.07(6)	S	*15.99*		•
PAVACOL D (Alliance Pharms)							
(pholcodine 5mg/5ml)							
cough liquid	150ml	314-8947	8.46(6)	S	*2.49* P		a
	300ml	031-2439	11.88(6)	S	*3.49* PCDI		a
PELICAN (Pelican Healthcare)							
colostomy bags							
opaque pouches			78.85(30)	S			
casual pre-cut 100520 32mm 088-8628							d
casual pre-cut 100521 40mm 088-8677							d
casual pre-cut 100522 45mm 099-4343							d
opaque pouches			83.10(30)	S			
closed pre-cut 100526 40mm 058-0647							d
closed pre-cut 100527 45mm 058-0654							d
closed pre-cut 100528 50mm 095-6615							d
closed cut-to-fit 100500 20-50mm 051-3838							d
closed pre-cut 100524 26mm 056-4294							d
closed pre-cut 100525 32mm 058-0639							d
disposable speculum							
with nut/threaded runner							
400105-small		210-8041	23.54(25)	S			d
400106-medium		210-8058	23.54(25)	S			d
400107-large		210-8066	23.54(25)	S			d
without nut/threaded runner							
400100-small		210-7993	23.54(25)	S			d
400101-medium		210-8025	23.54(25)	S			d
400102-large		210-8033	23.54(25)	S			d
drainable drainage bag							
night	133200-2 litre	338-0136	13.00(10)	S			c
PHLEXY-10 (SHS)							
Effective September 8							
capsules	200	221-0318	33.33	Z	BS		a
tablets	75	290-3615	129.54(6)	Z	BS		a
sachet	20g		100.51(30)	Z	BS		
blackcurrant & apple 210-5427, citrus burst 291-2822							a
tropical surprise 291-2830							a
PIRITON (GlaxoSmithKline Consumer)							
(chlorphenamine 4mg)							
tablets	500	022-0434	27.84(6)	S	P		c
PROMIX (Firstplay Dietary Foods)							
low protein							
burger mix							
lamb & mint							
4 sachets 72g		341-4927		Z	*5.50* BS		•
desserts - sachets	6 sachets 36.5g			Z	*5.15* BS		
custard 341-5031, caramel 341-5049							•
sausage mix	4 sachets 30g			Z	6.25 BS		
tomato & basil 341-4950, apple & sage 341-4968, original 341-4984							•
RITE-DIET (SHS)							
Effective September 8							
low protein products							
baking mix	500g	049-2819	118.98(18)	Z	BS		a
flour mix	400g	024-2982	102.24(18)	Z	BS		a
SERAVIT (SHS)							
Effective September 8							
Paediatric							
dietary supplement							
flavoured	200g	233-4654	59.76(4)	Z	BS		a
unflavoured	200g	233-4662	56.12(4)	Z	BS		a
SEROQUEL XL (AstraZeneca)							
(quetiapine)							
Effective September 15							
tablets 50mg	60	334-3415	67.66	S	POM		•
200mg	60	334-3423	113.10	S	POM		•
300mg	60	334-3431	170.00	S	POM		•
400mg	60	334-3449	226.20	S	POM		•
SNO-PRO DRINK (SHS)							
Effective September 8							
low protein milk replacement drink							
200ml		022-0293	26.46(27)	Z	BS		a
SORBION S (H&R Healthcare)							
hydroactive wound dressing (sterile)							
sachet 5 20cm x 10cm		333-8605	18.25	S	DT		d
5 20cm x 20cm		333-8613	34.25	S	DT		d
SULAZINE EC (Chatfield)							
(sulfasalazine 500mg)							
tablets	100	231-5497	7.15	S	POM		d
TARANIS (Firstplay Dietary Foods)							
low protein							
lemon cake bars	6 40g	341-5064		Z	*5.10* BS		•
THIXO D (Sutherland Health)							
thickener for dysphagic diets							
cal-free	30g	217-5941	14.00(6)	S	*3.99*		a
original	375g	077-7441	67.45(10)	Z	*9.45* BS		a
TOMMEE TIPPEE (Jackel International)							
FEEDING BOWLS							
magic mat & bowl	44039465	341-3044		S	*5.49*		•
twin compartment	43023461-	287-5227		S	*2.99*		•
VIAGEL (AMW)							
for men	25ml	341-3812	12.76	S	*24.99*		•
for women	25ml	341-3820	12.76	S	*24.99*		•
dual sachets							
lubricant	3	341-3374	5.10	S	*9.99*		•
WOT-NOT (Creative Max Imports)							
ponytailer		262-8758	1.70	S	*2.99*		d
XLEU ANALOG (SHS)							
Effective September 8							
special diet food	400g	208-0646	56.44(2)	Z	BS		a
XLYS ANALOG (SHS)							
Effective September 8							
special diet food	400g	004-3208	56.44(2)	Z	BS		a
XLYS MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	004-3190	153.88(2)	Z	BS		a
XLYS,TRY,LOW-MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	250-4090	153.88(2)	Z	BS		a
XMET ANALOG (SHS)							
Effective September 8							
special diet food	400g	023-6182	56.44(2)	Z	BS		a
XMET MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	024-7189	153.88(2)	Z	BS		a
XMET MAXAMUM (SHS)							
Effective September 8							
special diet food	500g	210-5914	246.68(2)	Z	BS		a
XMTVI ANALOG (SHS)							
Effective September 8							
special diet food	400g	023-6364	56.44(2)	Z	BS		a
XMTVI MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	024-7874	153.88(2)	Z	BS		a
XMTVI MAXAMUM (SHS)							
Effective September 8							
special diet food	500g	212-0863	246.68(2)	Z	BS		a
XP ANALOG (SHS)							
Effective September 8							
special diet food	400g	023-6117	90.16	Z	BS		a
XP ANALOG LCP (SHS)							
Effective September 8							
special diet food	400g	257-3855	102.56(4)	Z	BS		a
XP MAXAMAID (SHS)							
Effective September 8							
special diet food	500g		182.08(4)	Z	BS		
flavoured 013-0435, unflavoured 028-0412							a
XP MAXAMUM (SHS)							
Effective September 8							
special diet food	500g		281.56(4)	Z	BS		
flavoured 013-0443, unflavoured 028-1824							a
special diet food							
flavoured	30 50g	303-5995	422.28(2)	Z	BS		a
unflavoured	30 50g	340-4043	422.28(2)	Z	BS		a
XPHEN,TYR ANALOG (SHS)							
Effective September 8							
special diet food	400g	023-6265	56.44(2)	Z	BS		a
XPHEN,TYR MAXAMAID (SHS)							
Effective September 8							
special diet food	500g	024-7775	153.88(2)	Z	BS		a

Changes to Promotion Packs

		PIP code	Trade	VAT	Retail	
ACTIVE O2 (Anglo Bavarian Beverage Co)						
price marked pack						
oxygenated soft drink						
fitness	750ml		8.00(8)	S	*1.59*	
apple kiwi 721002 500-8792, iced berry 721003 500-8784						d
orange lemon 721001 500-8800						d
ALBERTO (Alberto-Culver)						
banded pack						
VO5 Advanced						
Perfect Lengths						
shampoo & conditioner twin pack	2 x 200ml	500-8628		S	*1.59*	d
BANANA BOAT (Energizer Group)						
counter/retail unit						
lip balm						
aloe vera & vitamin E						
spf 30	48 4.25g	500-7232	66.72	S		d
CLAIROL (Clairol)						
price marked pack						
Nice & Easy						
hair colour				S	*3.99*	
baby blonde 500-7216, black 500-7208, dark brown 500-7190						d
extra light neutral blonde 500-7158, honey blonde 500-7133						d
light ash blonde 500-7174, light beige blonde 500-7125						d
light brown 500-7182, medium ash blonde 500-7166						d
medium brown 500-7141						d
FIRST RESPONSE (Church & Dwight)						
price marked pack						
pregnancy testing kit						
double		500-8974		S	*7.99*	r
single		500-8966		S	*5.99*	r
KING OF SHAVES (Knowledge & Merchandising Inc) (distributors Ken Lamacraft Marketing)						
banded pack						
Azor range						
shaving gel - can						
sensitive with razor & 2 blades	200ml	500-9758		S	*4.99*	•
LUCOZADE (GlaxoSmithKline Nut H/Care)						
price marked pack						
Energy	1ltr		15.71(12)	S	*1.79*	
original 500-1268, orange crush 500-1276						d
LYNX (Unilever UK)						
banded pack						
shower gel	2 250ml			S	*2.19*	
africa 500-1342, boost 500-7356, chck 500-7364, recover 500-4379						d
snake peel 500-5962, unlimited 500-5970						d
MINERS (Miners International)						
counter/retail unit						
eyeball eyeshadows	36		20.52	S		
brown 500-6382, christma 500-6374, pink 500-6408, purple 500-6416						d
silver 500-6366, white 500-6390						d
PALMOLIVE (Colgate-Palmolive)						
price marked pack						
liquid hand soap	300ml			S	*1.00*	
antibac 500-9733, milk & honey 500-9741						•
shower gel	250ml			S	*1.00*	
anti stress 500-9717, milk & honey 500-9725						•

PIP code	Trade	VAT	Retail

Amendments to list of Generic Products

Symbols are •=new; i=insert; d=delete; c=change/correction

		PIP code	Trade	VAT	Retail		
ARACHIS OIL (Essential Generics)							
(arachis oil)							
enema	130ml	114-2520					c
BENZOIC ACID CO (Rusco)							
(benzoic acid co 6% w/w)							
ointment	500g	114-1373				PDT	c
CIPROFLOXACIN HYDROCHLORIDE (Chemidex Generics)							
(ciprofloxacin hydrochloride)							
tablets	250mg	10	111-0295		0.79	POMDT	d
	250mg	10	111-0311		0.79	POMDT	d
	250mg	20	111-0303		0.81	POMDT	d
	500mg	10	111-0329		0.87	POMDT	d
FLUVASTATIN (Sandoz)							
(fluvastatin)							
capsules	20mg	28	114-3130			POMDT	•
	40mg	28	114-3148			POMDT	•
GRISEOFULVIN (Essential Generics)							
(griseofulvin)							
tablets	125mg	100	112-4437			POM	c
	500mg	100	112-4429			POM	c

PIP code	Trade	VAT	Retail

Amendments to list of Manufacturers and Distributors

AMW UK Ltd i
(Code 1384)
Units 1b-3
Saxon Business Park
Littleport
Ely
Cambridgeshire CB6 1XX
Tel 01870 974 6853
Fax 01870 974 8650

Anglo Bavarian Beverage Co Ltd d
(Code 9989)
Unit 6 A
Cheddar Business Park
Wedmore Road
Cheddar
Somerset BS27 3EB
Tel 01934 743569
Fax 01934 744825
Email peth.katrin@yobuk.co.uk

Crazy Popular Products Ltd c
(Code 1596)
Emley Business Park
Emley
Huddersfield
West Yorkshire HD8 9QY
Tel 01924 840504
Fax 01924 840648
Email sales@crazypopular.com

Patientpak i
(Code 1381)
18 Hanover Square
London
SW6 1QJ
Tel 020 7386 8686
Fax 020 7381 5333
Email info@patientpak.com

Technovent Ltd i
(Code 1386)
Principality House
Western Valley Road
Rogerstone
Newport
Gwent NP10 9DS
Tel 01633 895994
Fax 01633 896558